PROPOSALS TO STIMULATE COMPETITION IN THE FINANCING AND DELIVERY OF HEALTH CARE

HEARINGS

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

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PROPOSALS TO STIMULATE COMPETITION IN THE FINANCING AND DELIVERY OF HEALTH CARE

WEDNESDAY, SEPTEMBER 30, 1981

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

[Press releases announcing hearings follow:]

[Press release of August 7, 1981]

Hon. Andrew Jacobs, Jr. (D. Ind.), Chairman, Subcommittee on Health of the Committee on Ways and Means, Announces Hearings on Proposals To Stimulate Competition in the Financing and Delivery of Health Care

The Honorable Andrew Jacobs, Jr. (D., Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, announced today the intention of the Subcommittee to hold hearings after the August district work period with respect to proposals to stimulate competition in the financing and delivery of health care. Although a specific date has not yet been scheduled, the hearings are being announced at this time in order to allow those who wish to testify ample opportunity to prepare. All those who wish to testify during these hearings are asked to submit their requests prior to September 11, 1981. The Chairman will announce, by press release, the date of the hearings as soon as they have been scheduled. At that time, each person who has asked to testify will be notified as to the day he or she is to appear before the Subcommittee.

BACKGROUND INFORMATION

Several proposals have been introduced in the 97th Congress to stimulate competition in the financing and delivery of health care. The major pieces of "pro-competitive" legislation introduced to date include: H.R. 850, National Health Reform Act of 1981 (Rep. Gephardt); S. 433, Health Incentives Reform Act of 1981 (Senator Durenberger); and S. 139, Comprehensive Health Care Reform Act (Senator Hatch). In addition, the Reagan Administration is presently preparing a "pro-competitive" proposal and has expressed its intention to submit legislation during this Congress.

While the bills which have been introduced to date vary, there are several elements which characterize the "pro-competitive" approach. The major elements of such proposals include changes in the tax treatment, for both employers and employees, of employer contributions to health benefit plans; establishment of incentives or requirements for employers to offer employees multiple choices of health plans subject to certain limitations with respect to coverage of services and cost-sharing including catastrophic benefits and preventive care; and establishment of medicare and medicaid voucher systems under which aged, disabled and low-income persons would receive a fixed-value voucher which could be used toward the purchase of a qualified health plan.

The Subcommittee seeks testimony on these concepts as well as other elements of the bills listed. In addition, the Subcommittee is interested in testimony on the effectiveness of these measures in containing health care costs; the impact of the proposals on providers, insurers, employers, employees, and beneficiaries of the medicare and madicaid programs; and problems of implementation and administration, adverse selection, effectiveness of incentives, and adequacy of coverage.

DETAILS FOR SUBMISSION OF REQUESTS TO BE HEARD

Individuals and organizations interested in presenting oral testimony at these hearings should submit a formal written request to be heard to John J. Salmon, Chief Counsel, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515; telephone: (202) 225-3625. Requests must be received by the Committee not later than the close of business Friday, September 11, 1981. Notifications to those scheduled to appear will be made by telephone as soon as possible after the filing deadline.

The limited time available to the Subcommittee for these hearings and the anticipated volume of requests to be heard require that all persons and organizations having a common position make every effort to designate one spokesman to represent them in order for the Subcommittee to hear as many points of view as possible. Time for oral presentations will be strictly limited with the understanding that a more detailed statement can be submitted for the Subcommittee's review and for inclusion in the printed record of the hearings. This will afford more time for interrogation of the witnesses by the Members of the Subcommittee. If it becomes necessary, the staff of the Subcommittee will group the witnesses into panels to expediate the hearings and will establish time limitations for each panelist. It will not be possible to change the date of the scheduled appearance once that date has been assigned—either the witness or a designated substitute for him must appear on that date or forego the opportunity to be heard in person. Organizations and persons scheduled to be heard are urged to notify the Committee office immediately of any change in the name of the witness or cancellation of a scheduled appearance.

PROCEDURE TO BE FOLLOWED FOR SUBMITTING TESTIMONY

The following is an outline of the procedure to be followed by organizations and individuals who may either want to appear and testify during these hearings or file a written statement for the printed record of the proceedings. All requests to be heard should also contain the following information:

1. The name of the witness, his title, address, firm affiliation and/or organization he will represent (as well as a telephone number where he or his designated representative may be reached).
2. If appearing in an individual capacity, a list of any clients at whose request or in whose employ the witness appears.
3. A topical outline or summary of comments and recommendations.

The above information should also be incorporated in the prepared statements to be presented in person as well as those filed for the printed record.

In order to assure the most productive use of the limited amount of time available to question hearing witnesses, witnesses scheduled to appear before the Subcommittee are required to submit 50 copies of their prepared statement to the full Committee office, Room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for the printed record of the hearings, five copies are required and may be submitted throughout the course of the hearings. An additional supply of statements for the printed record may be furnished for distribution to the press and public if supplied to the Committee office before the beginning of the final day of the hearings.

[Press release of Sept. 18, 1981]

HON. ANDREW JACOBS, JR. (D.-IND.), CHAIRMAN, SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON WAYS AND MEANS, ANNOUNCES DATES FOR PREVIOUSLY ANNOUNCED HEARINGS ON PROPOSALS TO STIMULATE COMPETITION IN THE FINANCING AND DELIVERY OF HEALTH CARE TO BE HELD ON SEPTEMBER 30, AND OCTOBER 1 AND 2, 1981

The Honorable Andrew Jacobs, Jr. (D.-Ind.), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today scheduled dates of the Subcommittee's previously announced hearings on proposals to stimulate competition in the financing and delivery of health care. The hearings are scheduled for September 30, and October 1 and 2, 1981 and will begin each day at 9:00 a.m. in room 1100, Longworth House Office Building, Washington, D.C.

Those individuals and organizations who have filed requests to testify in accordance with the Chairman's press release of August 7, 1981 (Health PR #2), have been scheduled as witnesses. No additional witnesses can be accommodated on the hearing schedule. Notification will be made as soon as possible, by telephone, as to the scheduled appearance of each witness. If a witness finds that he cannot appear as scheduled, he may file a written statement for the record of the hearing. Witnesses are reminded to submit at least 50 copies of their testimony to the Committee office, Room 1102 Longworth House Office Building, at least 24 hours in advance of their scheduled appearance. Failure to comply with this requirement may result in the witness being denied the opportunity to testify in person.

WRITTEN STATEMENTS IN LIEU OF PERSONAL APPEARANCE

For those who wish to file a written statement for inclusion in the printed record of the hearings, five copies are required and may be submitted to the Committee on Ways and Means. Written submissions for the record received by Friday, October 9, 1981, will be included in the official hearing record.

Chairman **JACOBS**. We shall begin our hearings on various proposals to interject by Government action competition into the health field.

The term itself is almost universally nebulous and the purpose of these hearings is to bring some focus and understanding to the proposals and possibly even some wisdom, which brings me to the subject of the first witness, Dr. Rivlin.

You are most welcome, as always, at the Ways and Means Committee and the Health Subcommittee thereof.

You may proceed in your own manner. I will not bore you with what is always told to witnesses about what you may or may not do.

STATEMENT OF ALICE M. RIVLIN, DIRECTOR, CONGRESSIONAL BUDGET OFFICE, ACCOMPANIED BY PAUL B. GINSBURG, DEPUTY ASSISTANT DIRECTOR FOR INCOME SECURITY AND HEALTH, HUMAN RESOURCES AND COMMUNITY DEVELOPMENT DIVISION

Ms. **RIVLIN**. I have with me Dr. Paul Ginsburg, who has done a good deal of work on competition in the health area. He heads up our health analysis at CBO.

I am pleased to be here to discuss proposals to stimulate competition in the financing and delivery of health care. My testimony will focus on the ability of these proposals to slow the rise in health care costs and their impact on the Federal budget.

BACKGROUND

The rapid rise in spending for medical care is now continuing after a brief pause in the late seventies. Per capita spending on personal health care has risen from $181 in 1965 to $941 in 1980—reflecting a 183 percent increase in prices and an 84 percent increase in the quantity of services. Moreover, under current policies, these trends are expected to continue for the foreseeable future. This continuing increase in medical costs will have a substantial impact on the Federal budget, making movement toward a balanced budget that much more difficult. Federal spending for medicare and medicaid will total approximately $58 billion in 1981 and, despite the substantial cuts just enacted, the Congressional Budget Office projects that it will increase to $85 billion in 1984, almost 11 percent of total spending in that year. The revenue loss from the tax exclusion for employer contributions to health insurance, which amounted to about $17 billion in income taxes and about $7 billion in payroll taxes in 1981, is projected roughly to double by 1986.

The Congress has been concerned with rising medical costs for some time, with its agenda dominated up to now by proposals to contain costs through regulation—proposals such as limits on hospital revenues.

Recently attention has turned to containing medical costs through encouraging the use of market forces.

STRATEGIES AND OPTIONS

Proposals to encourage the use of market forces to contain health care costs encompass two broad strategies. One is additional use of cost sharing in the financing of health care. Under this strategy, incentives to alter health insurance policies would induce individuals to increase both deductible amounts and coinsurance rates. The resulting increased cost consciousness would, in turn, reduce the use of health services and their prices.

The second broad strategy would encourage individuals to obtain their medical care through alternative delivery systems such as health maintenance organizations. HMO's have lower medical costs, principally because of lower hospital use. Some feel that a significant presence of HMO's also makes medical markets more competitive.

A number of specific policy options are available to pursue one or both of these strategies. Those of greatest interest to the committee today include: Altering the tax treatment of employer-paid health insurance, and permitting those eligible for medicare to enroll in a qualified private health plan, using a Federal voucher.

I will focus my comments today on these two options. A more detailed analysis of these and other options is included in a CBO study of H.R. 850, the National Health Care Reform Act of 1981, introduced by Representatives Gephardt and former Representative Stockman. That study, prepared at the request of the Ways and Means Committee, is also being made available at this hearing.

CHANGING THE TAX TREATMENT OF HEALTH INSURANCE

Those who propose to alter the tax treatment of employer-paid health insurance criticize current law because it encourages excessive purchases of health insurance which, in turn, result in greater use of health care services and higher prices. Since employer contributions are excluded from employees' taxable incomes, employers can provide a more attractive compensation package by favoring health insurance benefits over cash. The result has been comprehensive insurance packages with little cost sharing and a reduction in incentives to seek efficient ways of financing health care.

Moreover, the large revenue loss from this provision is distributed in a very uneven manner. Those with higher earnings get larger tax benefits, both because of their higher tax brackets and because employers with high wage scales tend to make larger contributions to health insurance. Those persons not earning wages or salaries, or in firms without health plans, get no tax benefits.

TAX EXCLUSION LIMIT

Many of the proposals to encourage market forces in health care—such as H.R. 850 and S. 433—would limit the amount of contribution that can be excluded from employees' taxable incomes. Such a ceiling would reduce spending on medical care by employed persons and their families, reduce medical care prices somewhat, and reduce the revenue loss from the exclusion. The magnitude of these effects, however, may make only a modest contribution to solving the health care cost problem.

Health insurance purchases would be reduced by removing the tax subsidy from the last dollars of contributions to health insurance. For example, if the limit were set at $120 per month for family coverage and an employee was receiving a contribution of $150 per month, $30 would be included in the employee's taxable income. Consequently some employees would prefer to have their employer reduce the contribution to health insurance by $30 and shift this amount to cash compensation.

This reduction in employer contributions could be translated into lower health insurance premiums in one of two ways. First, the comprehensiveness of benefits could be reduced, either by reducing covered services or by increasing the deductible amount and the coinsurance rate. This could be accomplished either by altering the employer's or the union's health package or by offering employees a choice of plans. The second way to lower health insurance premiums would be through enrollment in an HMO. Either approach would reduce the use of health services.

At least in the first few years much more of the response to this incentive would probably come in the form of greater cost sharing than through increased enrollment in alternative delivery systems such as HMO's. These plans play a relatively minor role in the medical care system today, and it is unlikely that they would be able to expand rapidly. Also, HMO premiums are often not significantly lower than those of the traditional insurance plans with which they compete, because their more comprehensive benefit packages offset their lower health care costs.

Two factors would limit this approach's effectiveness in controlling health care spending. First, it would only affect persons receiving contributions in excess of the limit. Such targeting is desirable, however, since it continues the incentive for all employed persons to have some health care coverage. Second, when health insurance benefits are cut back, benefits for hospital and physician services are less likely to be reduced than coverage for other services such as dental care and prescription drugs.

Limiting the tax exclusion would reduce the revenue loss from it, with the amount depending on the level of the cap. For example, a $140 per month limit for family contributions, effective January 1, 1982, would reduce the fiscal year 1982 revenue loss by about $2 billion.

TAX-FREE REFUNDS

A second tax option would permit an employer offering a choice of health plans to pay tax-free refunds to employees choosing plans with premiums lower than the firm's contribution. This option is frequently combined with the tax exclusion cap. Reluctance of employers to expand the number of health insurance plans offered to employees could apply their contributions to other firms' plans, as would be required under H.R. 850.

This approach would extend the incentives for lower health care premiums to a wider population than would a limit on the tax exclusion. First, persons with contributions less than the exclusion limit—who would be unaffected by it—would be able to gain financially from choosing lower cost health insurance plans. Second, alternative delivery systems, such as HMO's, would have additional markets opened to them.

The available evidence suggests that employers would be reluctant to offer a choice of plans. Even under present law, employers that require a contribution from their employees can offer a choice of health plans and reward those selecting plans with lower premiums. Yet these firms seldom take advantage of this opportunity.

Employers' reluctance to offer a choice of plans is likely to be related to concerns about adverse selection. Adverse selection in health insurance is the phenomenon of those likely to be low users tending to choose the low option plan and those likely to be high users tending to choose the high option plan. When premiums are based on claims experience, the result is a transfer of funds from those choosing the high option plan to those choosing the low option plan. Employers could find their health benefit costs increasing if the high option plan was their original plan and they felt compelled by tradition to contribute a fixed percentage of the premium to that plan. Adverse selection is a much smaller problem when the choice is between an HMO and a traditional plan because benefit differences are usually smaller and consumers' preferences for types of delivery system play a significant role.

Unrestricted tax-free refunds could reduce Federal revenues substantially. If the stricture that employees cannot take part of the employers' health benefit contributions in cash were removed, employers might increase their contributions, thereby sheltering more of their employees' compensation from taxation. That is the reason for combining this with the limit.

MEDICARE VOUCHERS

Given the substantial proportion of health care costs paid by medicare, a policy to encourage the use of market forces to contain costs might be more successful if medicare beneficiaries were included. One approach that has been proposed would give those eligible for medicare the choice between remaining under medicare and receiving a Federal voucher to pay for qualified private health plans. Those who purchased a qualified plan that cost less than the voucher would get a refund from medicare.

This option would increase enrollment in HMO's somewhat, by rewarding financially medicare beneficiaries who enroll in HMO's that have lower costs than medicare. Under current law, most HMO's are reimbursed by medicare on a fee-for-service basis, so that most of the savings from lower rates of hospital use accrue to medicare. In contrast, a voucher tied to average medicare costs would allow enrollees to share in the savings.

Vouchers would not, however, induce many medicare beneficiaries to opt for traditional private insurance plans, because insurers would face disadvantages in competing with medicare and would have to provide less coverage for the same cost. In particular, private insurers would have to include selling costs in their premiums, a cost that medicare does not have. These selling costs could be quite high, since the purchasers would be individuals, most of whom would not be reachable through employers. Also, medicare pays less to hospitals than do most private insurers—on average, 16 percent less than hospital charges.

Finally, insurers offering a more extensive benefit package than medicare would be at a particular disadvantage because of the inadvertent subsidies currently provided by medicare to those purchasing policies that supplement medicare coverage. These supplemental policies often reduce cost sharing, for example, by reimbursing the 10 percent of physician fees now not paid by medicare. This reduction in cost sharing induces more use of medical services, but the supplemental policy does not pay the full cost of these services. Instead, medicare pays a large proportion of them—80 percent in the case of additional physician visits. A private insurer offering a substitute for medicare plus the supplemental plan would have to pay the entire cost of the expanded use of services.

Two factors—adverse selection and the use of vouchers by those currently enrolled in HMO's—might actually cause medicare outlays to increase if the voucher approach were adopted. Adverse selection could result in increased medicare outlays because persons opting out of medicare would tend to be low users seeking plans with more cost sharing than medicare. This phenomenon might be aggravated by incentives to insurers to market selectively to attract the best risks. Greater use of HMO's would increase medicare costs since medicare would no longer reap the benefits of the HMO's lower costs.

A number of other "market-oriented" alternatives might be more successful than vouchers in containing health costs for those eligible for medicare. They include reimbursing HMO's on a capitation basis; applying a surcharge to supplemental premiums; restructuring medicare benefits to increase both cost sharing and catastrophic protection; and making vouchers mandatory.

Reimbursing HMO's on a capitation basis would establish incentives to enroll in HMO's comparable to the voucher proposal, but would reduce the extent of adverse selection. H.R. 3399, for example, would have medicare pay HMO's 95 percent of the per capita cost of medicare benefits, and would require HMO's to pass along to medicare enrollees the difference between the actual cost of services and the medicare payment to the HMO. Since most persons who would find vouchers attractive would probably enroll in HMO's, most of the potential of vouchers would be accomplished by this more limited policy change. Moreover, medicare would not be exposed to increased costs from insurers selectively marketing traditional plans with more cost sharing, leaving the high users to be served by medicare. A disadvantage to this approach is the need to define HMO and the possible exclusion of innovative plans not qualifying under that definition.

An alternative would be to discourage supplemental plans that effectively eliminate cost sharing under medicare by applying a surcharge to their premiums. This change would offset the additional cost such plans create for medicare by inducing increased service use.

A more direct approach to increasing cost sharing would be to change the medicare benefit structure. Cost sharing for the 2d through 30th day of a hospital stay could be introduced, for example, possibly in a form that would vary with individual hospital charges so that those choosing less expensive hospitals would pay less. Some of the savings to medicare could be applied toward increasing catastrophic protection, perhaps by adding an annual limit to cost sharing. Such an option would reduce the use of hospital care and increase the degree of price competition among hospitals. Those desiring more extensive coverage could still purchase supplemental plans. Its disadvantage would be the financial burden experienced by some beneficiaries, and the possibility that some would go without valuable care.

Finally, the voucher approach would have a larger impact if it were mandatory. Private plans would no longer be at a disadvantage in competing with medicare, and medicare outlays could be reduced, depending on the level at which the voucher was set. This option would have a number of disadvantages, however. First, adverse selection might be substantial, especially given the potential underwriting profits from favorable risk selection—resulting in large transfers among the elderly. Second, high selling expenses could increase the cost of financing health care for the medicare population. Third, the inherent complexity of health insurance plans leads to questions about the efficiency of requiring large numbers of people to make individual choices.

CONCLUSION

In summary, Mr. Chairman, changes in economic incentives can potentially slow the rise in medical costs and reduce Federal expenditures for health care. Of the available options, limiting the tax exclusion for employer contributions to employee health plans and incorporating greater cost sharing into medicare seem to be more efficient and direct than providing consumers with additional choices of health insurance plans. Such policy changes would result in lower use of medical care services and greater sensitivity to their prices, thereby leading to lower health care prices. Both private individuals and the Federal Government, through reduced expenditures for medicare and medicaid, would benefit.

Thank you, Mr. Chairman.

[The report previously referred to follows:]

An Analysis of the National Health Care Reform Act of 1981 (H.R. 850)

STAFF WORKING PAPER

PREFACE

The Congress is now considering proposals to contain rising health care costs by encouraging the use of market forces. This report, prepared at the request of the Committee on Ways and Means, analyzes one of the most comprehensive proposals of this type, the National Health Care Reform Act of 1981 (H.R. 850). In keeping with the mandate of the Congressional Budget Office (CBO) to provide objective and impartial analyses, this study offers no recommendations.

Paul B. Ginsburg, of CBO's Human Resources and Community Development Division, prepared this report, with a contribution by Thomas J. Buchberger, under the supervision of Nancy M. Gordon. The author wishes to acknowledge the valuable discussions he had with Gordon Trapnell, and the useful comments on earlier drafts by John Crosby, John Hoff, and Wendell Primus. Robert L. Faherty edited the manuscript, and Toni Wright prepared the paper for transmission to the requester.

Alice M. Rivlin
Director

September 1981

SUMMARY

The National Health Care Reform Act of 1981 (H.R. 850) addresses two major problems of the health care sector--rapidly rising costs and lack of access to services by some persons. It would attempt to solve the cost problem through competition--that is, increasing the role of prices in decisions made by patients and providers. At the same time, existing federal attempts to control costs through regulation would be repealed. The proposal would attempt to solve the access problem through federal financial assistance. Persons purchasing qualified health plans would all receive some federal assistance, either through the exclusion of a limited amount of employer contributions from taxation, through tax credits, or through vouchers.

The bill would reduce private spending on medical care, mostly through incentives to participants in employment-based health insurance plans to accept more cost sharing provisions such as deductibles and coinsurance, but also through encouraging enrollment in Health Maintenance Organizations (HMOs). Rates of use of medical services and prices would be somewhat lower than under current policies. Most of the impact on the federal budget would be on the revenue side, with a revenue loss amounting to $14.5 billion in fiscal year 1984 and increasing to $19.4 billion in 1986. Spending on Medicare and Medicaid would not change by a large amount.

Persons gaining the most would include those not currently receiving employer-paid health insurance and those who would qualify for low-income vouchers but who are currently ineligible for Medicaid. Those losing the most would include persons with large employer contributions to health plans and those receiving Medicaid who would not qualify for vouchers.

Tax Exclusion Limit

The bill would limit the amount of employer contributions for health insurance that could be excluded from employees' taxable incomes. The initial limit (in 1984) would be $154 per month. In addition, employees choosing plans with premiums below the employer's contribution to health insurance would receive tax-free refunds from the employer.

These provisions would tend to reduce health care costs since they would effectively remove much of the incentive to purchase health insurance that is provided by the current tax system. This, in turn, would probably lead to more cost sharing provisions in health insurance plans, lower rates of use of health services, and lower medical care prices. Some small increase in enrollment in Health Maintenance Organizations (HMOs) would also result, but this would involve many fewer people than the increase in cost sharing.

These provisions alone would increase federal revenues by a significant degree--about $4.9 billion in 1984 increasing to $11.9 billion in 1986--but other provisions would result in a net revenue loss if the bill were enacted. The tax increases would initially affect about one-third of those with employment-based health insurance, and would be concentrated on those persons obtaining the largest tax benefits today--those with high earnings, in unions, in firms with older employees, and in areas with high medical costs.

Tax Credits

The bill would provide refundable tax credits to purchase health insurance to all persons (except for the Medicare and Medicaid populations) not receiving employer contributions and to those receiving employer contributions less than the maximum permitted.

The tax credits would encourage somewhat the purchase of health insurance, but the proposed credit's small size relative to premiums of individually purchased insurance policies would limit the magnitude of this effect. A large proportion of the credits would go to persons already insured. While this widespread eligibility would increase the uniformity of the tax benefit, a substantial revenue loss would result in the process--$19.4 billion in 1984 and $31.3 billion in 1986.

Open Enrollment

The bill would require qualified health plans to accept all applicants and charge identical premiums to all persons within an actuarial category, although differentials that reflect administrative savings from group purchase would be allowed.

This provision might substantially alter the way in which health services were financed, weakening the link between employment and the purchase of health insurance. Its advantages include making health insurance available to the chronically ill and assuring a wide choice of plans for most persons. Its major disadvantage would be a potentially high degree of "adverse selection," the phenomenon of persons expecting high use tending to purchase plans with extensive benefits and those expecting low use to purchase plans with limited benefits.

Medicare Vouchers

The bill would provide vouchers to Medicare beneficiaries who would enroll in qualified private health plans. This provision would increase somewhat the number of Medicare enrollees served by HMOs, but would not induce many other beneficiaries to switch to private plans. The low amounts of the vouchers (compared with the Medicare benefits per enrollee) would discourage their use, as would the disadvantages that private insurers would face in competing with Medicare. Private insurers would have to include in their premiums both selling costs, which Medicare does not have, and higher payments for hospital care than Medicare reimburses. The adverse selection associated with this provision would increase Medicare outlays by a relatively small amount, but lowered medical care prices resulting from the bill's other provisions would tend to offset this increase.

Low Income Vouchers

In 1988, the fifth year in which the major provisions would be effective, the bill would permit states to replace their Medicaid programs with a federally administered system of vouchers for the purchase of private health plans. Substantial numbers of low-income persons who are ineligible for Medicaid because of categorical requirements would be able to qualify because eligibility would be based solely on income. On the other hand, some current recipients would lose their eligibility. Many states might decline to participate because they would be given increased responsibility for the costs of nursing home care, because elderly Medicaid recipients might have less access to health services, and because low voucher amounts would severely limit the number of health plans that would be able to provide the required benefit package without losing money.

AN ANALYSIS OF THE NATIONAL HEALTH CARE REFORM ACT OF 1981

The National Health Care Reform Act of 1981 (H.R. 850) addresses two major problems of the health care sector--rapidly rising costs and lack of access to services by some persons. It would attempt to solve the cost problem through competition--that is, increasing the role of prices in decisions made by patients and providers; at the same time, existing federal attempts to control costs through regulation would be repealed. The proposal would attempt to solve the access problem through federal financial assistance. Persons purchasing qualified health plans would all receive some federal assistance, either through the exclusion of a limited amount of employer contributions from taxation, through tax credits, or through vouchers.

Today, most health services are financed through private or public health insurance. Private health insurance tends to be provided through employment. Establishments accounting for about 90 percent of all U.S. employment offer their employees a health benefit plan with some contribution from the employer. A smaller amount of health insurance is purchased directly from insurers by individuals. Government provides health insurance for the elderly, the disabled, and others who are poor. The Medicare program covers 24 million aged and 3 million disabled persons, while about 29 million low-income persons are eligible for Medicaid. Nevertheless, between 5 and 8 percent of the population has no health insurance.

The bill has six major components:

1. Limit the exclusion from taxation of employer contributions to health plans, and require employers to pay refunds to employees who spend less than the contribution for a qualified plan. The limitation (approximately $154 per month in 1984 according to CBO projections) would initially be based on the value of Medicare benefits. Beginning in 1987, the limit would vary by actuarial category (for example, age, sex, family size, and location) and be based on the mean premium of qualified plans purchased by persons in a category in an area. Refunds paid to employees would be tax free up to $49 per month in 1984, reduced by any amount by which the premium plus refund exceeded the exclusion limit.

2. Provide refundable tax credits to those without employer contributions or with contributions less than the maximum excludable from taxation. The tax credits would be equivalent to the value of the average tax subsidy for those with employer contributions equal to the limit. In 1984, the credit for persons with no employer contributions would be approximately $58 per month. Those persons receiving employer contributions less than the maximum would receive smaller credits. Credits could only be applied to the premiums of qualified plans. Medicare and Medicaid beneficiaries would not be eligible for the tax credits.

3. Require all health plans to open their enrollment once a year and charge all persons in a given actuarial category the same premium. This provision is intended to sever much of the link between employment and health insurance. While employers could continue to contribute to their employees' health benefits costs and operate plans, the plans would have to enroll persons other than employees, and the firms' employees could take their contributions and enroll in plans not sponsored by their own employers.

4. Give Medicare enrollees the option of using a voucher to enroll in a qualified private health plan. Enrollees choosing a plan with a premium less than the voucher would have the difference refunded by Medicare. Those choosing a plan costing more than the voucher would pay the difference. The voucher would initially be based on average Medicare benefits (net of premiums) in 1982, indexed by the gross national product (GNP) deflator. The 1984 voucher amount for the average Medicare beneficiary would be approximately $1,845 per year. After a transition period, the voucher would be based on the average premium paid for qualified plans by those eligible for Medicare in an actuarial category and area who have enrolled in qualified private plans. Persons accepting vouchers would not be able to return to Medicare in future years, and once more than 50 percent of those eligible for Medicare have opted for vouchers, the vouchers would be mandatory.

5. Give low-income persons vouchers to purchase health plans with no cost sharing for covered services. This provision, which would not take effect until 1988, would make vouchers available to all low-income persons, regardless of family status, but only in states agreeing to participate. States participating would lose federal matching grants for Medicaid in return for federal underwriting of the full cost of vouchers for low-income persons. These states would be required to maintain Medicaid services that would not be covered by the voucher such as long-term care--about half of the current program.

6. Repeal various provisions of federal laws and preempt state laws thought to impede competition. The bill would repeal Medicare limits on reimbursements to providers, the PSRO program (which reviews the appropriateness of service use by Medicare and Medicaid patients), the federal health planning program, and much of the HMO Act. Any state law that impedes the reforms of the health care delivery system implemented under this bill would be preempted. Specifically preempted would be prohibitions against the corporate practice of medicine, discriminatory premium taxes, requirements that health plans provide certain services, regulation of premiums charged, and regulations on facilities that can be purchased or used or services that may be provided by hospitals or physicians.

This study analyzes each of these six major components of H.R. 850. Questions considered will include:

- impact on the medical care system,
- impact on the federal budget and the economy, and
- impact on the distribution of income.

The request for this study also asked about the impact of components of this proposal on the quality of care. Unfortunately, so little is currently known about the determinants of the quality of care that informed statements about the effects of components of this proposal are not possible.

The following section of this study discusses some basic issues about how increased competition might lead to lower health care costs. Then, each of the six major components of the proposal are analyzed.

COMPETITION AND COST CONTAINMENT

Use of private incentives can contain health care costs through at least two mechanisms. One mechanism is cost sharing, where the insurance contract requires the patient to pay part of the cost of medical care. If persons were induced to change the provisions of their health insurance plans to incorporate more cost sharing, they would reduce their use of health services.[1] Evidence also links cost sharing to lower medical prices.

A second mechanism is inducing persons to enroll in Health Maintenance Organizations (HMOs) or other alternative delivery systems. The research literature indicates that at least the prepaid group practice (PPGP) model of HMO achieves lower medical costs than insured fee-for-service practice. Some contend that increased enrollment in HMOs also reduces costs in the fee-for-service sector, once a substantial market share is obtained, but others disagree.

Some analysts envision increased use of market forces spurring the development of health plans which borrow some characteristics from HMOs but are less structured. These range from plans that place physicians who deliver primary care partially at risk for all services used by a patient, to plans that limit choice of providers to those who are low cost, to plans that give the patient financial incentives to choose low-cost providers. Whether the present limited use of these alternative plans reflects an absence of incentives to contain costs or serious drawbacks of the plans is a difficult question to answer.

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[1] The Rand National Health Insurance Experiment indicates that going from full coverage to 25 percent payment by the patient reduces service use by 15-20 percent. See Paul B. Ginsburg, "Altering the Tax Treatment of Employment-Based Health Plans," Milbank Memorial Fund Quarterly/Health and Society, vol. 59, no. 2 (Spring 1981), pp. 224-255, for a discussion of the evidence on this relationship and others that are discussed below.

incentives can contain health care costs. The bill focuses on competition between providers on the basis of price, quality, and method of delivery. It calls for

> health care deliverers to compete with each other for members based on cost, quality, and method of delivering care, thereby introducing incentives for the development of cost-effective, quality systems of health care delivery (Section 4(4)).

This view of competition appears to exclude some of the potential of the cost sharing mechanism, which does not need to be combined with competition to work. For example, an employer, responding to incentives from changes in the tax law, could increase cost sharing in the firm's single health plan. This additional cost sharing would induce employees and their families to reduce use, and might in turn induce providers to lower their fees (or raise them more slowly) even though they were not facing competition from other providers. Competition among providers might increase these price effects, however. While the authors of the bill appear to place great emphasis on incentives for the development of alternative delivery systems such as HMOs, the CBO expects that a major part of cost containment resulting from this bill would come through increases in cost sharing. The basis of this contention is explained in the following section.

TAX EXCLUSION LIMIT AND TAX-FREE REBATES

These provisions would induce individuals and/or their employers to spend less on health insurance. Most of those altering their health plans would probably increase the degree of cost sharing in their traditional health insurance plans. A smaller number would switch to HMOs or HMO-like plans that limit choice of providers.

Impact on the Medical Care System

The CBO has attempted to estimate the magnitude of the decrease in health service use and medical care prices that would occur as a result of the exclusion cap and tax-free refunds. In

1988, the fifth year that these provisions would be effective, health service use for the population covered by employment-based health plans is estimated to be about 6 to 9 percent lower than under current policies. Medical care prices would be about 1 to 2 percent lower than under current policies.[2]

Basis for Impact. The tax exclusion limit and tax-free rebates would remove most of the incentives to purchase comprehensive health insurance that are associated with federal tax subsidies.[3] Under current law, all employer contributions to employee health plans are excluded from taxation. In other words, compensation in the form of health insurance benefits is not taxed, while cash compensation is taxed, so it has been in the interests of both employers and employees to shift some compensation toward health insurance.

The exclusion cap would eliminate these incentives to shift compensation to health insurance for persons with contributions exceeding the cap. An additional dollar of compensation would be taxed regardless of whether it purchased health insurance or was in cash.

For employees receiving contributions below the cap, tax-free refunds would remove the subsidy to additional health insurance purchases. An employee deciding to purchase a health plan with a premium that is $10 per month less than the current plan, would have $10 per month more in after-tax income to be spent on other goods and services.

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2. The medical care price estimate relates only to the exclusion cap and tax-free refund provisions of H.R. 850. Other parts of the bill, such as tax credits and vouchers for low-income persons would tend to increase medical prices by increasing the demand for medical care services. CBO has not estimated the net impact of the entire bill, although it is expected that the direction of the impact would not change.

3. The bill would also deny to purchasers of qualified plans the subsidy to individual purchases of health insurance that is part of the medical expense deduction.

The research literature indicates that insurance purchases are moderately sensitive to subsidies, although deficiencies in the data limit the reliability of the results. Preliminary results from recent studies by the CBO and the Department of Health and Human Services (HHS) indicate that a 10 percent increase in the price of health insurance (the ratio of premiums to benefits) would, over time, decrease the amount of health insurance purchased by about 6 percent. Such a result is obtained from studies of variations in premiums for health insurance among employee benefit plans in firms of different sizes. The price of health insurance varies by firm size, permitting inferences about the effect of price on the purchase of insurance.

Inferences from these results are subject to error for three major reasons, however. First, the survey data used in the studies do not include information on the premium-to-benefit ratios faced by each firm--these ratios must be inferred from external data compiled by actuaries. Second, the research concerns decisions made by firms, either unilaterally or through collective bargaining, whereas the bill would rely more on the actions of individual employees to adjust health insurance purchases to new incentives. While it is reasonable to assume that firms and unions have made decisions concerning health insurance versus cash compensation that reflect employee preferences, their actions are only a rough guide to decisions that employees would make on their own. Finally, the methods employed in these studies do not permit any inferences about timing. Little is available to indicate how long it would take employees to adjust their health insurance purchases to the new incentives associated with this bill.

Specifics of Impacts. Employees increasing their cost sharing probably would not do so uniformly since coverage of some health services is more valuable to people than coverage of other services. The economics literature indicates that services that are expensive, nonelective, and not predictable are most likely to be insured.[4] Hospital care is the most likely service to be insured under this criterion, and in fact it is. Dental care and prescription drugs are much less likely to be insured.

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[4] See Paul J. Feldstein, Health Care Economics (Wiley, 1979), Chapter 6.

Those employees who increase their cost sharing are likely to concentrate the increase on those services where insurance is least valuable. This means that dental service and prescription drug coverage are likely to be reduced by the greatest proportion and hospital coverage the least. Such a pattern would tend to focus the effects of the bill on the health services where concern with spiraling costs is least intense.

Some recipients of employment-based health insurance would not have their incentives changed by the exclusion cap and tax-free refunds. Employees who are required to contribute to their firm's single health plan do not have the last dollars of their health insurance costs subsidized under current law. Since the employees' contribution is paid from after-tax income, the current tax system would not encourage purchase of a more expensive plan. Current law does not prevent the employer from offering a low option plan that would require a smaller contribution from the employee--equivalent to a tax-free refund.

Effects on HMOs. While removal of the tax subsidy would induce more cost sharing in health insurance, the impact on enrollment in HMOs or HMO-like plans is more difficult to predict. At present, many HMOs' premiums are higher than the premiums of the traditional insurance plans that they compete with, frequently the result of HMOs' more comprehensive benefit packages. Removing tax subsidies to the purchase of health insurance would not induce a switch to those HMOs that have premiums higher than the traditional plans that they compete with.

The relative premiums between HMOs and traditional plans could be changed by the bill, however. The bill would repeal sections of the Health Maintenance Organization Act that some feel have impeded the growth of federally qualified HMOs. Also, removing the incentives of the tax subsidy and requiring that the employer's contribution be invariant to the plan chosen by the employee would make it more attractive for HMOs to take steps to lower their premiums, either through efficiencies or by reducing the comprehensiveness of the benefit package.

Supply-side constraints might limit increases in HMO enrollment in the short run, however. Current HMO enrollment amounts to only 4 percent of the population. The research literature has established that prepaid group practice (PPGP) HMOs have lower costs than fee-for-service practice, though it is unclear whether independent practice association (IPA) HMOs have lower costs. But PPGPs cannot grow very rapidly. Some experts feel internal enrollment growth in established PPGPs cannot exceed 10 percent per year. Since enrollment growth under current policies (which includes new plans as well) has been about 10 percent per year, the margin for increases in growth induced by the bill is not very large. An immediate acceleration of enrollment growth to 14 percent per year that might be induced by the bill would amount to 10 percent of the population by 1988, the fifth year that these provisions would be effective, as opposed to 8 percent under current policies.

The bill could encourage the development of new types of plans, such as those limiting choice of providers to ones with low fees or ones that are frugal in ordering services. To the extent such plans are economical, elimination of subsidies to health insurance might make them more attractive. It is unlikely that the bill would produce a boom in such plans, however. Health insurance policies that reward the insured for using low-priced providers have been available for a long time and have declined in popularity. Commercial insurance policies in the past often paid a fixed dollar amount per hospital day or per physician visit. Now policies typically pay the full cost of hospital care and "usual, customary, and reasonable" physician charges. Limiting choice of physicians or hospitals to relatively low-priced ones would not be very different than these "indemnity" policies. While changes in the tax laws might reverse these trends, rapid shifts are unlikely.

Impact on the Federal Budget and the Economy

These provisions would increase federal revenues by a significant amount (see Table 1) but would have only a minor effect on outlays. In 1984, the first year that these provisions would be effective, revenues would be $4.9 billion higher than under current policies, with approximately two-thirds in income taxes and one-third in payroll taxes.[5] The combined revenue increase

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[5] The provision would be effective January 1, 1984. If in effect for the full fiscal year, revenues would be $7.0 billion higher than under current policies. Also increased payroll tax revenues tend to increase future Social Security benefit obligations.

TABLE 1. ESTIMATED IMPACTS OF MAJOR PROVISIONS OF H.R. 850 ON FEDERAL REVENUES (In billions of dollars)[a]

	1984	1985	1986	1987	1988
Tax Exclusion Cap (Revenue Increase)	4.9	9.3	11.9	10-15	13-18
Tax Credits for Those with Employer Contributions (Revenue Decrease)	8.3	12.5	12.9	7-10	6-9
Tax Credits for Others[b] (Revenue Decrease)	11.1	17.1	18.4	16-19	17-20
Net Revenue Impact (Revenue Decrease)	14.5	20.3	19.4	12-15	9-12

a. Excludes budget impact of Medicare vouchers, subsidies for graduate medical education, changes in Federal Employees Health Benefits Program, repeal of various provisions of Social Security Act and the Public Health Service Act. The net impact of these provisions which affect outlays rather than revenues is unlikely to be large compared to the impact of the provisions estimated. Low-income vouchers are excluded because the outlays are approximately equal in size to reductions in federal grants to the states for Medicaid.

b. Includes repeal of deduction for health insurance premiums.

would grow to $11.9 billion in 1986. Revenues in 1987 and 1988 are far more difficult to estimate, because the cap would be based upon average premiums for different actuarial categories and would vary by area. In 1988, federal revenues would be $13-18 billion higher than under current policies.[6]

Any effects of these provisions on federal outlays would come from indirect impacts on federal health programs such as Medicare and Medicaid. Reductions in medical care prices would lower outlays. On the other hand, increases in service use by those remaining in Medicare could occur as a result of reductions in use by the employed population. The freed-up hospital beds and physician time would increase rates of use by those whose care is financed by these programs. Many economists have documented how increases in medical resources tend to increase use of services.[7] Whether the price decreases or utilization increases would have a larger effect on outlays is difficult to predict.

While these provisions would lower medical care prices, the reduction would not be large enough to have a significant effect on the Consumer Price Index (CPI) for all items. In 1988, the CPI would be 0.1 percent lower than under current policies. This would be offset to some extent by the increase in the federal deficit and increased health spending from other provisions in the bill.

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[6] These revenue estimates assume that whatever shifts in the structure of compensation are induced by the bill will tend toward taxable rather than nontaxable compensation. (Specifically, 15 percent of health insurance contributions newly subject to tax would ultimately be shifted to nontaxable fringes while the rest would be taxed.) The reasoning behind this assumption is that capping the tax exclusion does not change the incentives to shelter earnings through contributions to pension plans or other tax-free fringes. Compensation shifted out of health insurance would be distributed to taxable and nontaxable components of compensation in the general proportions that they currently account for.

[7] For an estimate of the magnitude of the effects specific to Medicare, see Paul B. Ginsburg and Daniel M. Koretz, "Bed Availability and Hospital Utilization: Estimates of the 'Roemer Effect,'" August 1981.

One reason for this result is the relatively low weight that medical care has in the CPI. Since much medical care is paid for by employers and by the federal government through Medicare and Medicaid, rather than directly by consumers, its weight in the CPI is substantially lower than the proportion of personal consumption it accounts for.

Distributional Impact

During the transition period, when the cap on the exclusion would be uniform, it would have very uneven effects on taxpayers. Much of the uneveness would end with the transition period, however.

In 1984, the exclusion cap would affect about 32 percent of families with employment-based health coverage. The median increase in taxes for those affected would be about $25 per month. Those employees receiving the largest employer contributions would be affected the most. Also, those employees in the highest tax brackets would pay the most additional dollars in higher taxes.

Receipt of a large employer contribution can reflect one or more of the following:

- a rich benefit package,
- the employer contributing a high proportion of the premium, and
- actuarial factors causing the premium to be relatively high for a given degree of coverage.

A major issue of controversy is what proportion of the variation in employer contributions is associated with actuarial factors, such as the age of employees and local medical care prices, as opposed to the richness of the benefit package and the proportion contributed by employers. To the extent that actuarial factors are important, some would criticize a uniform cap.

The CBO has been analyzing this issue, and has found evidence that actuarial factors are important. Using a Bureau of Labor Statistics survey of employment plans, CBO constructed a premium index that reflected only variation in the comprehensiveness of coverage (including projected induced variation in use of care). This index deliberately excluded factors such as age, sex, and local medical care prices. Approximately 70 percent of these plans (weighted by the number of participants) had index values between 85 and 98. But family premiums, which include the other factors, had a much wider range. The comparable percentile range of family premiums ranged from $57 to $170 per month.

Though the ability to separate variation in employer contributions into these three components is limited, data are available to analyze who would be affected most by uniform ceilings. Employees in firms with high average wages tend to receive larger contributions. A univariate analysis of data on firms paying the full cost of health insurance (about 60 percent of firms with plans) indicated that for each 10 percent increase in average wages, health insurance contributions per employee increased 18 percent. Data also indicate that employees in firms with collective bargaining agreements have higher employer contributions, as do employees in firms in the Western and North Central regions. Employees in metropolitan areas also have higher employer contributions.

A distributional effect unique to this proposal is a much heavier impact on families than on single persons. Unlike other proposed tax exclusion caps, the one in this bill would be the same for single persons and families. Since single employees generally have much lower employer contributions than employees with families, they would be affected much less by the cap in this proposal. This uneven impact would not continue past the transition period because of the subsequent use of actuarial categories.

Such an effect could be eliminated by varying the cap by family size. If the uniform cap in the bill became a family cap, and a cap for singles were set at 40 percent of that level (a typical ratio between single and family coverage), the revenue increase would be about 18 percent greater. Health system impacts would be slightly larger.

When both husband and wife have employer contributions, the exclusion cap would be applied to the sum of the contributions. This would affect such families more than the exclusion caps in other proposals which treat each policy separately. Some would favor this, arguing that all families should be subject to the same cap, regardless of the number of earners. Others note that coordination of benefits provisions in health insurance policies make contributions received by dual earners worth less to them than contributions received by others, so that taxing the sum would be harsh.

After the three-year transition period, the cap would become nonuniform and would thus have a very different distributional impact. Each family's cap would be based on the average premium paid for qualified plans by families within the same actuarial category in an area. As a result, factors such as age, family status, and local medical care prices would not have much of an impact on the pattern of who would pay most in additional taxes. Those paying the most additional taxes would still be those in high tax brackets, with rich benefit packages, and whose employers contribute large proportions of the premiums, but would no longer include those in groups with high rates of spending on medical care for a given health benefit package.

TAX CREDITS

The tax credits in the bill would encourage those not now covered by health insurance to obtain coverage through a qualified plan. (Qualified plans are those that limit cost sharing for a defined set of services to $2,900 in 1982 and meet other conditions--see Title II of the bill.) This would reduce somewhat the problem of lack of access to the medical care system caused by the inability of some to afford health insurance. A large proportion of the credits would go to persons already covered by private health insurance, however, thereby substantially increasing the losses in tax revenues.

Impact on the Medical Care System

The tax credits would increase medical care spending and, along with the open enrollment provisions discussed in the next section, work toward severing the link between employment and health insurance coverage. A large proportion of the 5 to 8 percent of the population that is currently uninsured would purchase a qualified health plan with this tax credit. This increase in health insurance coverage would lead to higher medical spending, but would make the distribution of medical care spending more even.

The amount of health insurance that could be purchased with the tax credit would be modest. In 1984, the credit would amount to about $59 per month (38 percent of the cap). In that year, the average family premium for employment-related insurance is projected to be about $175 per month. Moreover, the size of the credit would decline relative to average health insurance premiums after the transition period. How much coverage such a currently uninsured person could purchase with the credit is difficult to determine, but cost sharing would have to be much more extensive than is commonly found today. The possibility exists that the tax credit would not be large enough to purchase the minimum benefit package specified for a qualified plan. This would be especially likely in high-cost areas during the transition period.

Not all of the currently uninsured would buy a qualified health plan with the tax credit. If the only plans available for the amount of the credit would have very high deductibles, persons who have low incomes and are currently making use of public clinics or hospital emergency rooms for care would have little motivation to purchase a health plan, lay out the money, and file for a tax credit. CBO studies of the Earned Income Tax Credit, which does not require purchasing something, estimate that only 63 percent of those eligible have filed for it. On the other hand, sales efforts by insurers and the proposal's requirement that recipients of Supplemental Security Income (SSI) and Food Stamps purchase a qualified health plan would work against these factors.

For those persons already insured, whether through employment or through individual policies, the opportunity to receive a tax credit would in most cases not have a large effect on the amount of insurance purchased. As long as the premium paid for a qualified plan already exceeds the tax credit amount, likely to be a very frequent case, no additional purchase of insurance would be necessary to receive the full amount of the credit that one is eligible for. The requirements for qualified plans would often mean a change in the benefit structure, however, reducing "first-dollar" coverage and increasing protection against catastrophic expenses.

The tax credit provision would remove one of the major rationales for associating health insurance with employment--the tax advantage. Since those families not receiving employer contributions would receive a tax credit roughly equivalent to the maximum tax subsidy for the average person through employment-related insurance that is permitted under the bill, the tax shelter motivation for employer contributions to health insurance would, for the most part, be removed. Only firms with employees in relatively high marginal tax brackets would find that the tax savings to their employees from an employer contribution would exceed the value of the alternative tax credit. For firms where the average marginal tax rate of their employees is lower than the national average, contributions to health plans would yield average tax benefits lower than what would be available from the credit.

Budget Impacts

The tax credit provision would result in a large revenue loss because so many would be eligible. With the exception of those families receiving employer contributions at or above the ceiling, the entire population not eligible for Medicare or Medicaid would be eligible for some credit. The revenue loss from tax credits would amount to $19.4 billion in 1984, and increase to $31.3 billion in 1986, the last year of the transition period (see Table 1).[8] Netting out the revenue increases from the tax exclusion cap, these provisions would result in an overall revenue loss of $14.5 billion in 1984 and $19.4 billion in 1986.

As discussed earlier, it is much more difficult to estimate the effects of H.R. 850 after the transition period. In 1987, the revenue loss from tax credits would be in the $24-28 billion

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8. These estimates include the revenue gains from the proposal's repeal of the health insurance deduction. They incorporate an assumption that 75 percent of those with no insurance coverage and 95 percent of those with individual insurance (not employer-based) would claim the tax credit. The estimate assumes that all persons with employment-based insurance who are eligible for a tax credit without changing the premium of their policy would claim the credit.

range. The revenue loss is smaller than in the transition period because the tax credits would be smaller. This would be the case especially for single persons, as the average premium for their actuarial categories would be much less than the uniform amount upon which all tax credits would be based during the transition period. Combining the tax credit and the tax exclusion cap yields a net revenue loss in the $12-15 billion range. In 1988, the revenue loss from tax credits would be in the $9-12 billion range.

The large budget impact during the transition period could be reduced by differentiating credits between single persons and families. If the amount in the bill became the family credit, and a credit for single individuals were established at 40 percent of that, the revenue loss from the tax credits would be reduced to $12.0 billion in 1984 and to $19.0 billion in 1986. Differentiating both the tax exclusion cap and the tax credit in this way would reduce the net revenue loss to $6.2 billion in 1984 and $4.9 billion in 1986. The alternative would not have a substantial impact on the revenue loss after the transition period, however.

Distributional Impact

The distributional effects of the tax credit provision of this proposal would be similar to those of the tax exclusion cap in the sense that those who lose the least from the exclusion cap tend to gain the most from the credit. Among persons with employer contributions to their health insurance, those receiving the smallest contributions would get the largest credits. Persons without employer contributions, who receive virtually no tax subsidies under current law, would gain the largest credits of all.

OPEN ENROLLMENT AND COMMUNITY RATING

The open enrollment and community rating provisions might cause a substantial change in the way health services are financed, largely by weakening the link between employment and health care financing. While the provision would make health insurance available to those "uninsurable" today because of chronic illness, adverse selection could pose a serious obstacle to full achievement of the proponents' goal of having a wide choice of health plans available to all.

The bill would require qualified plans to accept all applicants who pay the premium.[9] Premiums charged by plans could not vary among persons within an actuarial category except to reflect "any administrative savings effected by group purchases, or continuous membership in the plan over a specified period of years" (Section 204(c)). Employers would have to permit employees to apply contributions to health benefits to any qualified plan, even plans not sponsored by the employer.

Impact on the Medical Care System

The major impact on the medical care system would occur through changes in the financing of health care. The magnitude of change from these provisions would depend upon the extent to which employers are able to use the administrative savings clause to maintain current arrangements. Administrative savings associated with group purchase of insurance are substantial today. In very large groups, only 4 percent of premiums go toward administrative expenses, compared to about 35 percent for individual policies.[10] If employers that run plans give their own employees a substantial discount based on these savings, a substantial disincentive to joining outside plans would be established. Each firm's employees would tend to stay with the firm's own plan because of a much more attractive price. Indeed, in the absence of detailed regulation, employers might exaggerate the administrative savings in order to prevent high-risk persons from joining the plan. The extent of effective choice available to employees of large firms would thus depend on employer initiatives to make group purchases from a variety of plans.

An advantage of these provisions would be an improvement in access to health insurance by those who are uninsurable today. Persons who do not have access to an employer-sponsored group health insurance plan who have chronic health problems may not be able to purchase health insurance at any price. Most individual insurance policies exclude from coverage pre-existing conditions. Under the bill, such persons could purchase any health plan in their area, and pay the same premium as others (except for the adjustments for administrative savings).

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[9] If a plan reached its capacity, existing enrollees would be given preference. New applicants would be accommodated on a first-come, first-served basis.

[10] Unpublished tabulations from the Health Insurance Association of America.

A second advantage of these provisions is that they open the way for a large choice of plans for many employees. Except for the potential barrier of the administrative discounts, each person would have a wider variety of plans to choose from than if restricted to choices offered by their own employer. This would increase competition among health care plans.

Impact on Budget

The open enrollment provisions in H.R. 850 would have only minor impacts on the federal budget.

Distributional Impact

The most important disadvantage of these provisions is the additional exposure of health care financing to adverse selection. Adverse selection in health insurance is the phenomenon of persons who are relatively low users of services choosing those plans with less extensive benefits. When this occurs, the premiums of the "low option" plans are lower than would be the case if their enrollment were randomly selected from the population, and the premiums of the "high option" plans higher. This expanded premium difference encourages shifts out of high option plans, which may exacerbate the problem.

If adverse selection were severe, high option plans could not survive. The result would be a tendency to have only plans with benefits close to minimum requirements.

If adverse selection were less severe, the result would be a shift of income from the high users to the low users. Looked at in a different manner, choice with adverse selection reduces the extent of transfers from the low users to the high users by having expected utilization a factor influencing which experience pool persons go into. Many consider this redistribution a disadvantage of adverse selection. It appears to be a price that must be paid for the advantages of employing a choice of plans to further the use of market forces.

In situations where the choice is between a traditional insurance plan and an HMO, adverse selection is a different phenomenon. Here, the benefit structures are often similar, so the pattern of selection is more likely to be dominated by the differences between persons willing to change their physician and those who are not. As a result, PPGP model HMOs tend to attract a population of relatively low users. Since HMO enrollees tend not to switch back and forth, however, the phenomenon decays over time and thus is more important for new HMOs than for established HMOs.

Experience with Adverse Selection. Our limited experience with multiple choice in health insurance makes inferences about the gravity of the problem difficult. The Federal Employees Health Benefits Program (FEHBP) has offered a choice of plans for years. While it has not been studied extensively, the program appears to experience adverse selection. For example, the premium difference between the high and low options offered by Blue Cross and Blue Shield far exceed what would be expected on the basis of the benefit differences and the effects of those differences on use of services. A CBO analysis of plan switching in FEHBP indicates that those persons leaving the Blue Cross-Blue Shield high option plan are lower users than those remaining, although persons joining the plan have used services during their first year in amounts that are comparable to those already enrolled. Despite this adverse selection, however, the Blue Cross-Blue Shield high option plan is still the dominant plan, with 69 percent of the enrollment in the four government-wide plans and 50 percent of enrollment in all FEHBP plans other than HMOs. Inference from this experience is nevertheless difficult for two reasons:

- Possibly as a result of the formula for federal contributions, the range of choice available is quite limited. None of the options, for example, involve extensive cost sharing. Further, the federal contribution formula dilutes incentives to choose some of the low option plans that are offered, which in turn dilutes incentives for adverse selection.

- Simple tools to reduce adverse selection have not been employed in FEHBP. For example, premium differences among plans are not based on actuarial categories or location.

It is also difficult to make inferences from experience with multiple choice related to the underwriting of health insurance for individuals (as opposed to groups) because insurers often refuse to insure pre-existing conditions, a practice that would be illegal for qualified plans under this bill.

Adverse Selection under H.R. 850. Adverse selection could be extensive under this proposal because of the incentives to insurers to enroll low-risk persons. Insurers that are successful in enrolling low-risk persons would stand to make substantial underwriting profits, while those who enroll high-risk persons would experience substantial losses. Indeed, these profits and losses would probably be much greater in magnitude than the potential gains from innovation in the organization of the health plans to reduce the cost of medical care.

Despite the requirements in the bill that attempt to prevent it, insurers would have many ways to enroll relatively low users of services. The benefit structure could be tailored to attract healthy people. Examples include adding preventive dental benefits and excluding alcoholism and mental health benefits. In addition, marketing could be selective. Through selection of media and use of census tract data, insurers could direct their marketing to the relatively young persons in an actuarial category, or to people in types of occupations known to have low rates of medical care use. Vast creative energies might be channeled into ways to get an attractive pool of risks, energies that the sponsors hope to channel into finding ways to reduce the cost of medical care.

The adverse selection that might occur under this proposal would tend to reduce the extensiveness of health insurance benefits further than would be predicted from the change in tax incentives. While this might increase the extent of cost containment, it would have the negative side of increasing exposure to financial risk beyond what is desired and constraining too greatly peoples' use of medical services.

The extent of adverse selection would be much less under a system where employers would offer their employees a choice of plans. Under such an alternative, employers could use the same insurer to underwrite all of the plans offered, thus neutralizing the incentives described above to "skim the cream." Indeed, since employers would be hurt by adverse selection, through its raising the premium of the firm's basic plan, they would have strong incentives to innovate to reduce it. Innovations might include use of finer actuarial categories on which to base premium differences.

Other disadvantages of open enrollment include increased resources devoted to the administration of health insurance. Some of the extensive economies of scale associated with employment-related group health insurance would be lost. While insurance might be distributed to individuals at lower cost than the present 35 percent of premiums, the increase in administrative costs over those under current law would nevertheless be substantial.

VOUCHERS FOR MEDICARE ENROLLEES

Providing vouchers for persons eligible for Medicare to enroll in a private health plan would encourage some increase in enrollment in HMOs or other nontraditional plans that had lower costs than Medicare. The low amounts of the vouchers and the risk that they could be substantially less than the cost of Medicare benefits in the future would hold down the number who would take advantage of them, however, since few persons eligible for Medicare considering traditional private health insurance policies would find the vouchers attractive. Moreover, adverse selection against Medicare would cause increased federal outlays.

The Provisions

The bill would make vouchers available to all persons eligible for Medicare who wanted to join a qualified health plan. Eligible persons could apply the voucher toward a plan with a premium higher than the voucher and pay the difference, or get cash by purchasing a plan with a premium lower than the voucher. Persons opting for a voucher could not return to Medicare in the future. Once 50 percent of those eligible for Medicare had opted for vouchers, they would become mandatory.

During the transition period of 1984-1986, voucher amounts would be based on expenditures from the Medicare trust funds in calendar 1982, net of premiums, divided by the number of enrollees. The amounts would be indexed by the GNP deflator. Separate amounts would be established for the disabled and four actuarial categories of aged persons. The amounts would not vary by region, however.

After the transition period, the voucher amount would be based on the previous year's average premium paid by those using vouchers in an actuarial category in an area, indexed for one year by the GNP deflator.

Impact on the Medical Care System

Medicare vouchers would encourage the development of health plans which can achieve lower costs than Medicare. Under current law, enrollees gain little financial benefit from joining an HMO, and cannot receive credit for purchasing private insurance. Most HMOs are reimbursed by Medicare on a fee-for-service basis, so that most of the savings from their lower rates of hospital use accrues to Medicare. In contrast, under a voucher system, those enrolling in low cost plans would benefit from a portion of the savings. Such incentives would permit such plans to increase their enrollments. The shift to lower cost plans would contain medical costs.

While vouchers are attractive in theory, a number of problems--some specific to this bill and some general--would hold down the number of persons who would take advantage of such an opportunity. The problem specific to this bill is the manner in which the voucher amount is determined. The general problems involve the limited number of places in HMOs and the cost disadvantage faced by traditional insurers competing with Medicare.

Problems Specific to H.R. 850. Because the GNP deflator is expected to rise at a much lower rate than Medicare trust fund expenditures, the voucher specified in H.R. 850 would soon be worth much less than Medicare. Over the next five years, growth in Medicare benefits per enrollee are expected to increase at 6 percentage points per year in excess of the GNP deflator. This means that in 1984, the first year that this provision would be effective, the voucher would be worth 11 percent less than Medicare benefits. By 1986, the voucher would be worth 21 percent less. With savings from efficient HMOs thought to average about 20 percent, few financial incentives to enroll in HMOs would remain. In 1987 and thereafter, the voucher would be set equal to the average premiums for plans purchased by those eligible for Medicare. What this level would be is difficult to predict, but it is likely to be substantially below Medicare expenditures. As discussed below, those who opt out of Medicare are likely to do so in search of lower premiums, a tendency exacerbated by the low voucher levels during the transition period. Consequently, those persons contemplating the voucher, who cannot return to Medicare once they leave, would be dissuaded by both the initial low voucher amounts and by the risk of future voucher amounts being even lower.

This problem could be resolved either by more generous indexing during the transition period, or by tying the voucher to future Medicare expenditures. The medical care component of the CPI would come closer to reflecting increases in medical care spending, but still would not reflect the growth in spending associated with service increases from new technology as opposed to price increases. An additional allowance might be added to reflect this.

Alternatively, the voucher amount could be set at some percentage (for example, 95 percent) of Medicare expenditures per enrollee. This would limit the financial risk to those opting out. Once those taking vouchers reached a certain percentage of the Medicare eligible population, the voucher could then be based on the average premium for qualified plans. This approach would avoid the phenomenon of a sharply diminished Medicare program dictating the size of vouchers.

Other Problems. One of the more general obstacles to this approach involves the difficulty that private insurers would have in competing with Medicare. Private insurers have selling costs while Medicare does not, and selling insurance to individual aged and disabled persons could be very expensive. The active role prescribed for the Department of Health and Human Services in informing eligible individuals of the plans available to them would certainly reduce selling costs, but it would not eliminate them.

Private insurers costs would also be higher because they often must pay providers at higher rates than Medicare does. The problem is most serious in hospitals, where Medicare does not permit additional charges to the patients. Data from the Health Care Financing Administration indicate that, in 1976, Medicare reimbursements to hospitals were 16 percent less than charges. Recent calculations by insurance company actuaries indicate that the differential has since grown.

The problem of private insurers competing with Medicare is particularly acute with respect to those interested in a richer benefit package than Medicare provides. Today, such persons may purchase private policies to supplement Medicare. These purchases of supplemental policies are implicitly subsidized by Medicare, however. The reduction in cost sharing that results from such purchases induces higher rates of use of medical services, but Medicare pays a large proportion of the costs of the additional use.[11] If a private insurer were to offer a richer benefit package as a substitute for Medicare and the supplemental plan, it would have to include in its premium the entire cost of the additional utilization induced by the richer benefits.

These competitive disadvantages of private insurers would tend to rule out use of vouchers to purchase traditional health insurance plans, but might still permit purchase of other types of plans. Plans that might be purchased would include HMOs and other plans that have cost advantages over traditional health insurance or plans with very extensive cost sharing. HMOs are available to some of those who are eligible for Medicare but, as was discussed above, their present small market share would limit the number of persons who would be able to take advantage of these opportunities.

Some persons could opt for traditional health insurance policies with extensive cost sharing. Premiums for such policies could probably be substantially below Medicare expenditures per enrollee, although an important part of the saving might be absorbed by selling costs and higher reimbursements. With almost no data on the demand for health insurance by the elderly, forecasting the demand for such policies is very difficult.

Use of vouchers to purchase insurance policies with extensive cost sharing would have two effects on the health care delivery system. First, use of health services would be lowered in a manner similar to that described in the section on exclusion caps. Second, bad debts might increase. Those eligible for Medicare could purchase a plan with the minimum coverage required by the bill (a plan with a $2,900 deductible) and be unable to pay their medical bills should they get sick. To the extent that care is delivered anyway, its cost would tend to be borne by other payers or local governments operating public hospitals.

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[11] As an example, the supplemental plan might pay the 20 percent coinsurance for physician services. But if physician visits increase by 20 percent, Medicare would pay 80 percent of the fees for the additional visits. In this example, Medicare would pay 40 percent of the full costs of additional coverage.

Budget Impact

While these provisions would result in some containment of health care costs, federal outlays would more likely be higher than lower. Two reasons for this are

-- Current Medicare savings from HMO enrollment, and

-- Adverse selection.

Since the Medicare program currently benefits from lower costs its enrollees experience in HMOs, use of vouchers by those enrollees could increase Medicare outlays. Despite the lack of incentives to join HMOs under current law, about 540,000, or 2 percent, of all those eligible for Medicare are members. Most of these persons joined HMOs through employment and maintained their membership upon reaching age 65. But most of this care is currently reimbursed on a fee-for-service basis, so Medicare outlays for any voucher that would be attractive to these persons would necessarily exceed current Medicare reimbursements on their behalf.

Adverse selection would increase Medicare costs as well because those who would choose to use vouchers would likely be relatively low users of services. Since Medicare vouchers would be more attractive to those seeking plans with lower premiums than Medicare than to those seeking plans with high premiums (and more extensive benefits), Medicare would lose more of its low users than its high users. This tendency could be exaggerated during the transition period by enrollees in low cost areas being more likely to seek (and find) plans with premiums below the uniform voucher amount than those in high cost areas.

Evidence from demonstration projects indicates that those Medicare enrollees switching to HMOs had lower expenditures during the years before enrollment than other Medicare enrollees of similar age and sex in their area. The most recent analyses of a carefully supervised enrollment process indicate a 20 percent difference in prior expenditures for those joining HMOs that required a change in physician.[12] Analysts explain this pattern as one of persons with less recent contact with the medical system being more willing to change physicians.

Alternatives

A number of alternatives to the vouchers proposed in H.R. 850 would increase the attractiveness of more cost sharing and avoid the potential increase in Medicare outlays. They include:

-- reimbursing HMOs on a capitation basis;

-- applying a surcharge to supplemental premiums;

-- restructuring Medicare benefits to increase both cost sharing and catastrophic protection;

-- offering a choice of plans within Medicare; and

-- making vouchers mandatory.

Reimburse HMOs on a Capitation Basis. This option would establish incentives to enroll in HMOs comparable to the voucher proposal, but would reduce the extent of adverse selection. Under H.R. 3399, for example, Medicare would pay HMOs 95 percent of the per capita cost of Medicare benefits. If HMOs were able to provide the service for less, they would either reduce their premium to the enrollee or increase services. If most persons who would find vouchers attractive would enroll in HMOs, then most of the potential of vouchers would be accomplished by a much more limited policy change. Moreover, Medicare would not be exposed to increased costs from insurers selectively marketing traditional plans with more cost sharing, leaving the high users to be served by Medicare. A disadvantage to this approach is the need to define "HMO" and the possible exclusion of innovative plans not qualifying under that definition.

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[12] Paul W. Eggers, "Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in 'At-Risk' HMOs," Preliminary Findings, June 26, 1981.

Apply a Surcharge to Supplemental Premiums. Applying a surcharge--a fee to offset additional costs to Medicare--to premiums for supplemental plans would eliminate the current subsidy to them. While somewhat difficult to estimate, the magnitude of this subsidy is probably substantial. A user charge would compensate Medicare for the amount of this subsidy through two mechanisms--transferring amounts collected from those continuing their supplemental policies and reducing claims by those terminating them through an effective increase in the amount of cost sharing.

Restructure Medicare Benefits. A more direct approach to increasing cost sharing would be a change in the Medicare benefit structure. Cost sharing for the second through thirtieth day of a hospital stay could be introduced, for example, possibly in a form that would vary with individual hospital charges so that those choosing less expensive hospitals would pay less. Some of the savings to Medicare could be applied toward increasing catastrophic protection, perhaps by adding an annual limit to cost sharing. Such an option would reduce the use of hospital care and increase the degree of price competition among hospitals. Those desiring more extensive coverage could still purchase supplemental plans. Its disadvantage would be the financial burden experienced by some beneficiaries, and the possibility that some would go without valuable care.

Choice of Plans Within Medicare. Medicare could, alongside of its present plan, offer a series of plans with different benefit structures. Refunds or extra premiums would be based on actuarial categories and reflect the experience of the alternative plans. Since Medicare cannot run HMOs, a provision for paying HMOs on an incentive basis, such as would be provided for in H.R. 3399, would be a useful component of this option. The surcharge on premiums for supplemental policies discussed above would also be a useful component of this option. Choice of plans within Medicare would, relative to the voucher proposal, increase the attractiveness of cost sharing and reduce adverse selection and its effects on Medicare outlays.

This option would make cost sharing attractive because the advantages of Medicare in lower reimbursements to providers and the absence of selling costs could be retained in the process of choosing a different benefit structure. Indeed, the moderate adverse selection likely to be experienced would make a plan with higher cost sharing particularly attractive to many Medicare beneficiaries.

A second advantage over the voucher proposal would be a reduction in adverse selection, since Medicare would design and market the alternative plans. The situation of private insurers profiting or losing money according to their ability to select the best risks would be avoided. While some adverse selection would nevertheless remain, it would have no financial consequences to Medicare. Those persons choosing plans with more cost sharing would tend to gain, while those choosing more comprehensive plans would tend to lose.

A disadvantage of this option is that opportunities for innovative health plans might be lost. While HMOs would still be encouraged, a line would have to be drawn between plans eligible for such reimbursement and those that were not. Innovative plans that were not eligible would not be able to market to the Medicare population.

Mandatory Vouchers

Making vouchers mandatory would avoid the problems of private insurers competing with Medicare, but would suffer from other problems inherent to Medicare vouchers. It would permit reductions in Medicare outlays, however. Vouchers could be phased in by making them mandatory only for those newly eligible for Medicare.

Mandatory vouchers would permit broad competition among private health plans for Medicare enrollees, but would suffer from a number of problems. First, adverse selection might be substantial, given the potential underwriting profits from favorable risk selection. While such adverse selection would not affect the federal budget, large shifts of income from the high users to the low users might occur. Second, the significant costs required to distribute the private plans to the Medicare population would tend to increase the cost of health care for them. Third, the inherent complexity of health insurance plans leads to questions about the efficacy of requiring large numbers of people to make individual choices.

Mandatory vouchers would reduce Medicare outlays as long as the voucher amounts did not grow as rapidly as Medicare benefit payments would under current policies. On the other hand, the vouchers could be increased rapidly enough to avoid such a reduction in what is now an entitlement to services.

VOUCHERS FOR LOW-INCOME PERSONS

The bill would permit states to replace their current Medicaid programs with a federally administered system of vouchers for the purchase of private health plans. The amount of the voucher would probably be less than the cost to most insurers of financing the health care use of low-income participants and, thus, the choices of low-income persons would be limited to a few plans. On the other hand, substantial numbers of low-income persons who are ineligible for Medicaid would be able to qualify for vouchers because eligibility would be based solely on income. Many states, however, would probably elect not to participate in this system of vouchers because states would be required to continue to support a portion of the cost of covered services and would also be given increased responsibility for nursing home care, which would not be covered by vouchers.

The Provisions

Beginning in 1988, the bill would provide a voucher to persons whose incomes fell below the federal poverty guideline to enable them to purchase coverage from a qualified private health plan.[13] Qualified plans for low-income persons would have to cover the same services as those required for Medicare vouchers (hospital and physicians' services, prescription drugs, and medical supplies), but could not have cost sharing provisions. The low-income elderly and disabled would be required to give up Medicare in order to receive a low-income voucher because receipt of benefits from both Medicare and Medicaid would no longer be possible in those states participating in the program. The amount of the voucher would be an average of the premiums for all persons in an actuarial category within a specific area purchasing a qualified plan, plus the average of out-of-pocket expenditures incurred by plan members in that area.

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13. Persons with incomes between the poverty level and the poverty level plus twice the value of the voucher would be eligible for a reduced voucher.

States electing to participate would be responsible for their current (1981) Medicaid costs adjusted for inflation, although the voucher plan itself would be financed directly by the federal government. After 1988, the portion of federal Medicaid grants that states now receive for services not covered by the proposed vouchers (most notably nursing home care) and for persons now eligible for Medicaid who would not qualify for a voucher would be reduced by an amount equivalent to what states now expend for acute care under Medicaid adjusted for increases in the GNP deflator. The proposal's maintenance of effort provision would also transfer to the states the sole responsibility for increases in excess of the GNP deflator in expenditures for long-term care costs, and other services excluded from the health care proposal. States would become solely responsible for administration of long term care and other excluded services.

Impact on the Medical Care System

The effect of the provision of these vouchers on demand for medical care is uncertain, because the proposal would extend coverage to many who currently have no health insurance but it would also reduce coverage for some who are now eligible for Medicaid. The total number of persons estimated to be eligible for vouchers, about 30 million, would not be significantly different from the number of persons projected to be eligible for Medicaid.

About 8.4 million single persons and 1.8 million childless couples who are now ineligible for Medicaid would receive vouchers. These persons could be expected to demand greater quantities of medical care than under current policies.

On the other hand, others who would have their coverage reduced as a result of this proposal could be expected to demand less medical care. For example, the low-income elderly and disabled who are currently covered by both Medicare and Medicaid would receive less coverage because they would be required to choose either a low-income voucher or Medicare only. Also, because eligibility for vouchers would be based upon income received over a period of at least three months, many current Medicaid recipients would lose eligibility.[14] The proposal would not readily permit persons to qualify for periods of less than three months.

By basing the amount of the low-income voucher on the average of premiums for all plans in a geographic area and the average out-of-pocket expenditures of plan members, the proposed vouchers could be inadequate to purchase from most plans the full coverage that is required. In most instances, premiums would reflect the lower rates of use of medical services that would be found in insurance plans that have cost-sharing provisions for most members. In contrast, vouchers could be used only to purchase plans with no cost sharing. The difference in rates of use would be exacerbated by the greater health care needs of the poor.[15] In addition, the reports by plans of average out-of-pocket costs that would be used to determine the voucher amount would probably underestimate the costs because many out-of-pocket costs are not claimed by insured individuals. The relatively small size of the voucher could make many insurers unable to meet the minimum requirements at the cost paid by the voucher.

The low voucher amount might also cause many people eligible for Medicare to decline the voucher in order to remain in Medicare. Since the amount of the voucher for this group would be based upon the average premium of plans selected by those who have opted out of Medicare, even with an allowance for out-of-pocket expenditures, the voucher amount might not enable the recipients to purchase better coverage than that provided by Medicare.

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14. A consequence of Medicaid's use of a monthly accounting period for most persons is that many recipients, about 20 percent in 1977, had coverage for three months or less. Gail Wilensky, Daniel C. Walden, and Judith A. Kasper, "The Changing Medicaid Population." Paper presented at the 1980 annual meeting of the American Statistical Association, August 11, 1980.

15. By many measures, low-income persons use more medical care than do those with higher incomes; however, many of these differences appear to be due to differences in health status. Much of the difference in health status between those with low income and other persons is due to a greater prevalence of chronic conditions among low-income persons than among the general population.

Finally, the low voucher amount could restrict the choices of recipients to practices specializing in low-income patients. This could perpetuate the different health care system now used by many poor individuals because of the current reluctance of physicians to accept Medicaid patients at the program's low reimbursement levels. As a result, almost 60 percent of all Medicaid patients currently receive care in practices where Medicaid patients account for at least 30 percent of all patients.

The problem of low voucher amounts could be overcome by basing the size of the voucher on the expected cost of providing care to persons with low income. The value of vouchers could be set at different levels for the disabled, and for other types of low-income families, to reflect their different medical needs. Increasing the size of the voucher would raise the cost to the federal government, however. For example, the voucher would have to be increased by about 15 percent just to compensate for the greater demand for services that would result from the absence of cost sharing for recipients of vouchers. An additional increase would be required to reflect the greater health needs of this population.[16]

On the other hand, increasing the voucher amount to encourage more plans to enroll persons receiving low-income vouchers would reduce incentives to select efficient low-cost health care plans. Persons enrolling in a low-cost plan who present a voucher worth more than the plan's premium would not be given a rebate of the difference. The plan would be reimbursed only its premium amount and the federal government would receive the full benefit of the recipient's prudent choice.

Budget Impact

If all states participated, federal expenditures for low-income health care under the proposal would be roughly equal to projected outlays for Medicaid which would be replaced, so that

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16. Although adequate data are currently unavailable to permit adjustment of the voucher amount to reflect the greater use of medical services due to the lower health status of recipients, estimates of this adjustment could be developed by surveying the potential eligible population prior to implementation of the proposed voucher plan.

there would be no net budget impact.[17] The cost of providing health insurance vouchers would be about $25 billion. In addition, federal grants to states for noncovered services, after applying the state maintenance of effort provisions, would amount to $2 billion.

In spite of the extension of federally assisted health care to many previously ineligible persons, the proposal's cost does not significantly exceed projected Medicaid costs because of eligibility reductions and reductions in covered services. To a large extent, growth in eligibility would be offset by elimination of coverage for many current Medicaid recipients. Services covered by the proposal do not include one of the most costly of Medicaid's covered services, nursing home care. The low amount of the vouchers relative to the cost of providing medical care to low-income persons also limits the cost of this proposal.

Distributional Impact

The proposal would affect both states and individuals.

Impact on States. A large number of states would probably elect continued participation in Medicaid rather than the low-income voucher plan because their financial responsibility for providing medical care to low-income persons would not necessarily be reduced and could significantly increase under the voucher. The proposed voucher plan would relieve states of some of the financial responsibility of providing acute medical care to low-income persons. States would not be responsible for acute care costs that exceed their 1981 level adjusted for increases in the GNP deflator. For many states, this relief would be smaller than the costs of their increased responsibility for nursing home care and other services not covered by qualified health insurance plans.

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[17] The estimate of the bill's effect upon outlays assumes participation by all states in low-income vouchers. This assumption was necessary because of the uncertainty of state choices to participate and the unreliability of estimates of individual state expenditures seven years in advance.

The rising cost of noncovered services, especially nursing home care, would be a paticularly severe problem for states choosing to participate. Between 1973 and 1978, Medicaid expenditures for services that would be covered by the health care vouchers rose at an average annual rate of 13 percent, compared with an average annual rate of 19 percent for services that would not be covered by the voucher. This rapid increase in expenditures for services that the vouchers would not cover was due largely to their increased use, and the population most likely to use them--the elderly--will continue to grow during the 1980s. Moreover, prices for these noncovered services would not be directly affected by enhanced competition in the provision of covered services.

States might experience an increase of $1 billion to $2 billion over expected Medicaid costs because of their expanded responsibility for nursing home costs. Because states would have full responsibility for the provision of nursing home care and other noncovered services, they might be able to restrain the cost of these services by developing more efficient alternative methods of providing care. For example, states could expand the range of noninstitutional services to reduce the need for more costly nursing home care.[18] The extent to which home care and other alternatives to nursing home care could reduce long term care costs may be limited, however.

Impact on Individuals. Among those who would lose Medicaid eligibility are the working near-poor and the medically needy. At present in states with a high payment standard for Aid to Families with Dependent Children (AFDC), families may qualify for public assistance and thus for Medicaid even though a household head worked full-time for much of the year. Many of these families would no longer be able to meet the income eligibility standard for vouchers. In addition, persons would no longer be able to qualify for medical assistance if their income after deducting medical expenses were below income eligibility standards. All of these persons, however, would receive either employer contributions for health care coverage or refundable tax credits to purchase coverage. Persons who receive a tax credit in place of Medicaid coverage would probably have much less extensive health insurance than the coverage provided by Medicaid or low-income vouchers.

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[18] The Omnibus Budget Reconciliation Act of 1981 contains provisions that permit states to apply for waivers to offer many alternatives to institutional care.

The proposal's eligibility requirements would reduce the number of persons who are eligible for federally subsidized health care and who have annual incomes significantly above the federal poverty standard. Eligibility for a year beginning in January would be based upon annual income received in the 12-month period ending the previous June. Alternatively, an individual could establish eligibility at any time during a year, if income for the previous 3-month period were below one-quarter of the yearly income eligibility standard and if income for the next 3-month period was expected to continue to be below the income eligibility standard. Although normal fluctuations in earnings could boost annual incomes of some persons above the income eligibility standard, this is less likely to occur under the voucher proposal than under current Medicaid rules that use a monthly accounting period. To reduce costs to the government of vouchers received by people with incomes above poverty guidelines, the proposal provides for recovery of voucher amounts paid to plans on behalf of individuals who are also covered by employer health care contributions. Administration of this provision could be cumbersome, however.

REPEAL OF REGULATORY PROVISIONS OF FEDERAL HEALTH LEGISLATION AND PREEMPTION OF STATE LAWS

The proposal would dismantle some of the federal apparatus that attempts to contain costs through regulation. It would also preempt some state activities in this area, as well as many state laws that, though not intended to contain costs, might impede competition.

While such repeals and preemptions would certainly reduce regulation, they are probably not critical to the success or failure of the rest of the bill. For the most part, these provisions have impacts on the medical care system that are less important than the likely impacts of the provisions of H.R. 850 discussed above. While repealing each of these provisions might or might not be desirable, failure to do so would not jeopardize the ability of the rest of the bill to contain health care costs.

Analysis of these changes should proceed on a case-by-case basis, although such a task is beyond the scope of this report. The CBO has studied one of the programs slated for repeal--the Professional Standards Review Organization (PSRO) program--at the request of this Committee's Subcommittee on Oversight.[19] The CBO is also in the process of studying the federal health planning program at the request of the Senate Labor and Human Resources Committee. These studies are designed to assist the Congress in its consideration of these specific repeals.

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[19] See Congressional Budget Office, The Effect of PSROs on Health Care Costs: Current Findings and Future Evaluations, June 1979, and The Impact of PSROs on Health-Care Costs: Update of CBO's 1979 Evaluation, January 1981.

Chairman Jacobs. Thank you, Dr. Rivlin.

Mr. Gephardt?

Mr. Gephardt. Thank you, Mr. Chairman.

I would like to thank you and the subcommittee for taking the time to hold these hearings which I think are very important, especially in light of the fact that we see a continuing increase in health care costs and a continuing concern about them. It would appear to me as we go through these budget cuts we are now facing that health care has to be one of the areas we have to look at in order to deal with the budget cutting and bring some sense to the financial markets.

On page 10 of the study Mr. Ginsburg did, we have estimates of the revenue impact or the savings impact of the provisions of H.R. 850.

I would like to know if these figures include any savings that might be anticipated from changes in prior behavior?

Ms. Rivlin. Since you identified Dr. Ginsburg as the author of this paper, I think I will let him answer the question.

Mr. Ginsburg. Yes. The estimates for 1987 and 1988, do include some savings from changes in prior behavior.

Since the bill sets a predetermined ceiling on exclusions for health insurance, the revenue effects initially are not influenced by what happens in the medical care system. That is all deferred until 1987, after the transition period proposed in the bill.

Mr. Gephardt. Is your theory that there would not be enough prior behavior in the first years because of the transition?

Mr. Ginsburg. No, not that at all. I think that medical care prices would begin to fall compared to what they would have been otherwise from near the beginning, although such effects do take time. But the bill is written in such a way that those reductions in prices would not affect either the revenues from the tax exclusion cap or the cost of the tax credit until after the transition period. Revenue effects after the transition period would be based upon average health care plan premiums paid. But during the transition period, your bill uses the 1982 medicare expenditures as the basis for taxes and tax credits.

Mr. Gephardt. The second question is, in your opinion, is the present health care system price competitive?

Ms. **Rivlin**. Certainly not as price competitive as it could be by a long shot.

The fact that many people have very low dollar coverage and are subject to very little cost sharing, makes them less price conscious than they would otherwise be.

Mr. **Gephardt**. I would like to ask along that line then, what is preventing it from being more price competitive and how can price competition be increased?

Why do you think that the provisions in H.R. 850 or bills like it could increase competition, or do you think it wouldn't?

Ms. **Rivlin**. I think there is a good chance it would. It is very hard to predict what would happen to the medical care system with such provisions, but there is substantial evidence that increasing cost sharing does reduce the use of health services. To that extent, I think there is a good chance that the kinds of plans we are talking about today would have an effect on increasing competitiveness and reducing use.

Mr. **Gephardt**. The traditional ways we have tried to hold down health care costs of medicare and medicaid are to increase regulation to hold down the costs.

Are those not simply ways to ration health care, or to limit the amount of health care, and isn't that just another way of achieving health care savings?

I guess my question is, what would be the difference between the traditional ways that we have tried to hold down health care costs and the ways that are expressed in the various bills for competition?

Ms. **Rivlin**. The approaches are not necessarily incompatible. Although traditional methods discussed, are not very much used, they have been regulating the prices charged by medical care producers—that is, setting fee schedules. But there are other ways of regulating prices besides price setting.

Clearly, one effective way would be to provide reasons for the users of medical care services to worry about prices more than they now do. The objective of increasing cost sharing or increasing choice on the part of the consumer is really to put the burden of thinking about prices back on the consumer and the provider, and to provide incentives for keeping the costs from rising as rapidly as they have.

Paul may want to add to that.

Mr. **Ginsburg**. I would like to reinforce the fact that I think our experience with regulation in the health care field is actually very limited. The history has been proposals to regulate particularly hospital prices, and most of those proposals have not passed. The proposals that have been implemented have tended to be limited to the medicare and medicaid programs. For instance, limits have been placed on hospital reimbursement in those two programs. While no one has actually evaluated whether these limits have contained hospital costs, many do not expect them to because they only apply to part of the hospitals' business.

Actually, our most extensive experience with regulation has been at the State level. About eight or nine States have tried to limit hospital revenues. The early experience in those States has been fairly favorable as far as reduced rate of cost increase. It is difficult to project from this as to how long a slowed rate of cost growth can be kept up, but that experience has been somewhat favorable.

Mr. GEPHARDT. Thank you very much, Mr. Chairman.

Chairman JACOBS. Mr. Duncan?

Mr. DUNCAN. Thank you, Mr. Chairman.

Dr. Rivlin, how much cost of the increasing costs in per capita medical care is attributable to unnecessary and burdensome regulation?

Ms. RIVLIN. I don't know that anybody has a number for that, or even a good way of estimating it.

Mr. DUNCAN. Are you familiar with a report that was issued by the Director of the Office of Health Regulation, Dr. John Reiss? I think for some reason it never surfaced from the department

Ms. RIVLIN. It didn't surface on my desk. Maybe Dr. Ginsburg knows about it.

Mr. GINSBURG. No. I have never heard of it.

Mr. DUNCAN. Are you familiar with it, Doctor?

Mr. GINSBURG. No, I am not.

Mr. DUNCAN. The office was set up by the Carter administration to try to determine where there have been duplicative and unnecessary or burdensome regulations.

In fact, it is one of the most comprehensive reports I have read. It happened to be given to me just recently.

They say, among other things, that the office consistently questioned the operating agencies about the reasons for the rules with little result, but they do indicate they did get good cooperation from the Office of Management and Budget in this report.

Mr. Chairman, I would like, if possible, that we consider having Dr. Reiss testify. He isn't in the present administration—he could come as a witness. I think the minority has the right to call witnesses.

Chairman JACOBS. I am quite sure any testimony would be helpful.

Mr. DUNCAN. It is very informative. I would like for him to be here to explain it.

Chairman JACOBS. Any witness from the administration would be more than welcome.

Mr. DUNCAN. He isn't in the present administration.

Chairman JACOBS. As I understand competition, it is the cornerstone of the administration's new economics. We are very anxious to hear it defined to see what this is—it isn't October yet, but we are hoping that there will be some word from the administration.

Mr. DUNCAN. I don't know why the report wasn't published. Or, if it was published, it was never distributed.

They indicate that 20 percent of all the information on the reports requested from HMO's is duplicative and unnecessary.

I have no further questions, Mr. Chairman, other than that request.

Chairman JACOBS. I am sure that will not be difficult.

Mr. GRADISON. If the gentleman will yield, I concur with him.

Chairman JACOBS. Now, I call on my ranking member, Mr. Rangel.

Mr. RANGEL. Thank you, Mr. Chairman.

Unless I missed something, there is no administration health plan before this committee or the Congress, is that correct?

Chairman JACOBS. Well, I am not sure. Has anybody checked the mail this morning?

Up until last night I think that was the case.

Mr. RANGEL. So we are dealing with competition as certain of our colleagues have defined it in proposed legislation.

I want to know, under this or any other plan, is there any limit to how much health coverage a person may have if he or she wants it?

This doesn't restrict my ability to buy as much health insurance as I want, does it?

Ms. RIVLIN. No.

Mr. RANGEL. So the competition is supposed to be in the free marketplace as it relates to insurance companies and health providers. Are they supposed to compete against each other in order to get increased premiums?

Ms. RIVLIN. Well——

Mr. RANGEL. In other words where is the competition?

Ms. RIVLIN. Pardon me?

Mr. RANGEL. We use competition in these programs, don't we? I want to know who is competing with whom for what?

Ms. RIVLIN. You are——

Mr. RANGEL. As I understand it, the insurance company will be competing for potential patients or clients. In return, the insured will look the various plans over and decide which plan is best for them?

Ms. RIVLIN. Yes.

Mr. RANGEL. Isn't that competition?

Ms. RIVLIN. That is correct. The idea of some of these changes—for example, putting a limit on the amount of employer contribution that the employee can have tax-free—would be to give the employee some incentive to buy a lower cost plan, a plan with higher coinsurance and deductibles.

Mr. RANGEL. It penalizes the employer if he provides excess coverage, and it penalizes the employee if he or she gets excess coverage, right?

Ms. RIVLIN. It could make having more coverage less advantageous than it is now. That is another way of looking at it.

Mr. RANGEL. Having coverage is a pretty emotional and real right—not right, strike that out.

It certainly is a good feeling to know that you have hospital and health coverage, and if the employer has incentives to reduce it through the threat of penalty, and you have incentives to get rebates, the tendency is to reduce the requested insurance package, if you will. Therefore, somebody has got to decide what is excess, right?

Ms. RIVLIN. That is right. Clearly, it feels good to have health coverage. On the other hand, many people covered by employer plans may have more health coverage than they would actually buy if——

Mr. RANGEL. That is the point. Who would determine——

Ms. RIVLIN. Let me finish the sentence. They would have more health coverage than they would actually buy if given a choice between more health coverage and more income, when both were treated the same by the tax system.

Mr. RANGEL. Who would be inclined to get more—to take the option for more income and opt for less coverage in the future?

Ms. RIVLIN. Oh, I think lots of people might—particularly people who consider themselves relatively healthy or who are not worried about being able to cover small or medium-sized medical bills on their own.

Mr. RANGEL. What guidelines do we have in any of the legislation that assists the potential claimant in projecting his or her future health needs?

Ms. RIVLIN. The legislation does not offer such guidelines. We do know—and it is part of a problem that affects health insurance—that people have reasonably good predictors of what their health status is.

Mr. RANGEL. They do? You mean people who buy health insurance have a reasonable projection as to whether they are going to be sick or need hospital coverage?

Ms. RIVLIN. Yes. Within broad limits. People who already know they have a serious health problem are more likely to want higher coverage.

Mr. RANGEL. Oh, well, if you have a serious health problem, how does free competition work with insurance companies?

They wouldn't want a whole lot of sick people applying for insurance, would they? Wouldn't they, under the free market system, decline coverage to that group of people? Not decline, but increase the premium, wouldn't that make sense?

Ms. RIVLIN. As we pointed out in the testimony, that is one of the problems with the proposals. There would be some adverse selection.

Mr. RANGEL. Will not the insurance companies increase your premiums, if your car is located in a poorer community, where it is inclined to have an accident, or if you live in a community that is inclined to present health problems? Would not they follow these sound, free market, competitive principles?

Ms. RIVLIN. To some extent, yes.

Mr. RANGEL. So the easiest way to handle it is to find out who has the propensity to get sick, what age group, and to allow the whole force of the free marketplace to work to increase their premiums so that those who project a healthy future will find insurance plentiful and cheap and those who are ill will find it scarce and expensive. Isn't this how it will work?

Mr. GINSBURG. Mr. Rangel, I don't think any of the so-called procompetitive proposals are proposing to have a health insurance market as free and decentralized as you are imagining.

If insurance companies sold insurance to individuals, what you are suggesting probably would happen. Companies would try to avoid the worst risks and get the best risks. But many of the bills leave in place the system we have today—that is, most insurance is purchased by groups of employees, by a union, or by a firm for their employees.

Mr. RANGEL. Suppose you belong to that group and you are in an old-age home. What are your chances of being placed?

Mr. GINSBURG. So far the rules that most of these groups have used—and I don't think these bills would change those rules—are that all full-time employees in a firm are eligible to participate in the plan.

Mr. Gephardt's bill, H.R. 850, gets away somewhat from the employment-based system. Even so, his bill has a lot of rules to prevent insurers from behaving as you suggest. There is some question as to whether the rules would be successful. But I think that all of the authors of competitive proposals are very much aware of that problem and have tried in one way or the other to account for it.

Mr. RANGEL. My last question is, if I bought or a group bought the least expensive plan, projecting accurately their future health needs, and that health need did occur, is there anything in any of the plans that prevents the doctors, the hospitals, or the insurance companies from increasing the rates so that what was a fair need now becomes one that cannot be paid for? Are there protections against that?

Mr. GINSBURG. I don't quite understand. Increasing their premiums?

Mr. RANGEL. For example, say you buy an auto insurance policy with a $50 deductible. There is no cap on it. Then your car breaks down; you go to have it repaired, and they say costs have increased since you bought your policy.

You are just going to have to get lesser care for your car.

Could that possibly happen where the insurance companies and the doctors and the hospitals get together—I know they don't but for purposes of discussion, let's say they do—and adjust my average coverage, so as to reduce the amount of care I am going to get for the dollar I paid.

Is that possible under any of these competitive plans, or would the insured be protected?

Mr. GINSBURG. Currently, the type of regulation you are talking about—to protect the purchasers of insurance from practices like this—tends to be done at the State level. I think the Federal Government has been specifically precluded from that type of regulation of health insurance. It has been left to the States. Some of the proposals, like Senator Durenberger's, would not affect that type of regulation.

Under H.R. 850, there would be somewhat of a shift in that regulation toward the Federal Government. It contains the notion of a qualified health plan. Title 2 of this bill lists all of the requirements that plans have to meet. Presumably, the Federal Government would make sure that those requirements were being met.

Mr. RANGEL. Thank you.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Gradison?

Mr. GRADISON. Thank you, Mr. Chairman.

Dr. Rivlin, I would like to inquire of what strategy or strategies you think Congress should be considering later in this decade or earlier to deal with the expected shortfall of revenues for medicare?

The latest report of the trustees projects that sometime around the end of this decade the fund, which now is in a healthy surplus, is going to be in financial trouble. I am interested in any comments you might have or any work which you might have underway with regard to alternative means of anticipating and dealing with this situation. I also want to try to understand whether the procompetitive proposals that we are talking about today, in your judgment, fit into some kind of a framework of trying to deal with this expected financial crisis in medicare?

Ms. RIVLIN. In response to the question about what strategies the Congress ought to be considering, I would answer "all of the available possibilities." Medicare has to be seen in two ways: as a specific program, and as a part of the larger problem of medical care provision.

The elderly constitute a very expensive portion of the population to provide medical care for. In that sense, the medicare program, which is specifically for the elderly population, is possibly always going to be an expensive program. But one can think about ways of reducing the cost of medicare, and I think the voucher proposal is certainly one way that deserves thought. We suggested some other possibilities in the testimony itself that might be less drastic, but perhaps equally effective. These alternatives include raising the cost sharing in medicare, making it more expensive to have supplementary medigap plans, and changing the reimbursement for HMO's so that there is more incentive for older people to join HMO's.

On the other hand, there is the wider context. The medical care prices for the elderly will reflect the degree of use of medical care generally and what is happening to medical prices generally. I think you also have to think about the entire medical cost problem and it is in that context really that the tax changes, if they were successful in slowing the rise of medical care prices and in reducing overall use, would have an indirect effect on Federal programs ultimately.

Mr. GRADISON. It seems to me that in social security, particularly in the old age fund, we are now seeing that it not only reacts to changes in the economy, but it affects the economy; that is, decisions made in social security about retirement age influence behavior and therefore influence the economy. Some will argue that the way we finance social security influences the savings rate, things of that kind.

It occurs to me that the same general principle probably applies to medicare. To my knowledge, medicare is the largest single purchaser of health care anywhere in the economy, unlike medicaid where there are 50 systems. Here is a single system for the elderly paid for by one purchaser.

I guess I am wondering whether we are taking full advantage of the market power which we have as the purchaser for this group right now.

I support the voucher system and H.R. 850. I think that competition is a useful approach to impending financial problems with the medicare system. I wonder more directly whether there aren't possibilities of our using the fact that this represents a substantial proportion of the income of individual hospitals or individual doctors or so forth to try to bring down those prices for this group by taking bids or by some other traditional market means of getting the best deal we can for the people we are looking out for, that is for whom we are acting as the purchaser of health care benefits?

Have you examined that question?

Ms. RIVLIN. I think that is clearly right. The Government could use more market power than it does to get lower prices for Medicare beneficiaries specifically. What that would do to the rest of the system is not clear. The danger is that, if the reimbursement rates for medicare were lower, then providers would simply load these charges onto everybody else, and there would be no substantial benefit.

Paul, do you want to speak to that?

Mr. GINSBURG. Yes. I think you really hit on an important point, Mr. Gradison. When medicare was enacted, people failed to think of the possibility that has come to fruition: Because the program is so large, it has affected the health care system in a very substantial way. The great increase in third-party payments probably is one of the reasons that medical care costs increased so rapidly.

This really opens two options for controlling costs. As you noted, medicare—as a large purchaser—could take some steps to lower its outlay substantially. Some of this reduction would probably be shifted to the private sector; some of it may cause providers to change this behavior and lower their costs. The other option is on the benefit side. But whatever medicare does will affect the health care system in a major way. We always have to keep that in mind in thinking about changes in the program.

Mr. GRADISON. Thank you. Very useful.

Thank you, Mr. Chairman.

Chairman JACOBS. Dr. Rivlin, do you see any danger from the medicare voucher proposal that old people might end up selling their medicare rights for a mess of pottage or whatever might be bought with the cash they might be given, thereby releasing the Government from its obligations?

Ms. RIVLIN. You are suggesting that medicare beneficiaries might underestimate their need of coverage and take the cash instead, in order to have immediate cash, but that they might end up with high cost sharing which they might later not be able to afford. I think that is not a trivial danger.

Chairman JACOBS. On the question of the market strength of the medicare program, and the effect on other portions of the market if reimbursements were arbitrarily limited, and the observation that the medicare program itself has possibly had an impact on prices generally in the health field, what do you suppose would be the result if, in the case of hospital reimbursements, the medicare program emulated its policy toward nursing homes and simply stated if a hospital charged its patients more than the American Hospital Association guidelines then that hospital would be relieved of Government bureaucracy in toto because the medicare program would not shop at that hospital but instead would terminate the contract, if the prices generally charged by that hospital were excessive? Is that using Uncle Sam as a prudent purchaser?

Ms. RIVLIN. Paul?

Mr. GINSBURG. If I am correct, the difference between what you are talking about and what Mr. Gradison was is that he was talking about medicare payments only, and you are talking about medicare using its power to influence prices to all purchasers?

Chairman Jacobs. Medicare will not shop at Rive Gauche or wherever? That is the concept.

Mr. Ginsburg. A proposal like that would probably give substantial incentive to hospitals to get under the maximum established by the program. The question is how do you establish the right shopping level, taking into account the fact that hospitals treat different kinds of patients and perform more or less complex services.

This involves a serious technical problem. Clearly, you would be influencing hospitals more than simply changing medicare reimbursements.

Chairman Jacobs. Under such a program, you would not be telling hospitals what to charge. You would just tell hospitals what they would have to charge if they want to have a contract with the Government. They don't have to have the contract.

The committee is grateful to the Congressional Budget Office, Dr. Rivlin, Mr. Ginsburg, for your contributions.

Mr. Rangel?

Mr. Rangel. I am concerned about this excess care. I have a feeling that the Members that will be voting on this probably have excess care. We should be more competitive.

Is preventative care considered competitive care or could that be considered excess medical care in these bills that you have studied?

Ms. Rivlin. These bills do not write particular health care packages. In general, they attempt to include preventative care. With health insurance, however, generally most people choose to have hospital care, which often results from not having enough preventative care, the most heavily covered.

Mr. Rangel. So the goal would be to eliminate unnecessary medical treatment, unnecessary surgery, unnecessary hospital days? That would be the goal of the competition?

Ms. Rivlin. I think that the goal is to make both patients and providers more conscious of costs when they seek care, and that the hope is to reduce unnecessary care and to provide care more efficiently because the customer has some reason to think about the cost.

Mr. Rangel. Thank you.

Chairman Jacobs. Any other follow-up questions?

Mr. Gephardt. Just one, Mr. Chairman.

Chairman Jacobs. Mr. Gephardt?

Mr. Gephardt. Dr. Ginsburg, in 1984 you say the revenue increase because of the cap would be $4.9 billion, but the decrease because of the credit for the difference between the plan chosen and the cap would be $8.3 billion?

Mr. Ginsburg. That is right.

Mr. Gephardt. So, there would be a revenue loss between those two figures in 1984?

In 1985 is this still a revenue loss, but it is not as great. In 1986 there continues to be a revenue loss, but again, it is again not as great. It is down to about $1 billion revenue loss.

My question is, as you know in H.R. 850 we set the cap for individuals and for families the same; and obviously individuals can buy plans less expensively than families, but yet they would enjoy the difference between the plan they choose and the cap.

My question is if the bill were revised to have a different cap for individuals who purchase single person policies as opposed to family policies, would this revenue loss be as great?

Mr. **Ginsburg**. If the bill were revised to have different caps for individuals and families, the revenue loss from the bill would be lowered substantially. In the course of preparing this report, we looked at an alternative where the cap in the bill would apply to families and the cap for individuals would be 40 percent of that rate, which is the average in existing health insurance. Under that alternative, we estimate a revenue loss in 1984 of $6.2 billion rather than $14.5 billion. In 1986, we estimate a $4.9 billion revenue loss rather than $19.4 billion.

The first two lines of the table you were questioning me about treat the revenue effects for the population with employment based coverage. Under the alternative, those provisions of the bill would produce a net revenue increase. That would be offset by the tax credits for people who don't have employer-provided coverage.

Mr. **Gephardt**. Can you give me the net revenue increase on the first two lines for 1984, 1985, and 1986? Do you have it that way?

Mr. **Ginsburg**. I have it but not with me. I could supply it for the record.

Mr. **Gephardt**. Fine. Of course the third line is the tax credit in the bill for people without any employer coverage at all?

Mr. **Ginsburg**. That is right.

[The following was subsequently received:]

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

Alice M. Rivlin
Director

October 22, 1981

Honorable Richard A. Gephardt
U.S. House of Representatives
Washington, D. C. 20515

Dear ~~Congressman~~ Dick:

During my testimony before the Ways and Means Health Subcommittee on September 30, you asked for more detailed budget estimates of a possible modification of H.R. 850 involving lower tax exclusion limits and tax credit amounts for single persons.

These estimates are attached. In order to permit comparisons, we have used the same format as Table 1 in the background paper released at the hearing.

If we can be of further assistance, please let us know.

With best wishes,

Sincerely yours,

Alice M. Rivlin
Director

Attachment

TABLE 1A. ESTIMATED REVENUE IMPACTS OF MAJOR PROVISIONS OF H.R. 850 AS MODIFIED BY SETTING TAX EXCLUSION CEILINGS AND TAX CREDITS FOR SINGLE INDIVIDUALS AT 40 PERCENT OF THE AMOUNTS SPECIFIED IN THE BILL (In billions of dollars)[a]

	1984	1985	1986
Tax Exclusion Cap (Revenue Increase)	5.8	11.0	14.1
Tax Credits for Those with Employer Contributions (Revenue Decrease)	4.5	6.5	6.5
Tax Credits for Others[b] (Revenue Decrease)	7.5	11.6	12.5
Net Revenue Impact (Revenue Decrease)	6.2	6.1	4.9

a. Excludes budget impact of Medicare vouchers, subsidies for graduate medical education, changes in Federal Employees Health Benefits Program, and repeal of various provisions of Social Security Act and the Public Health Service Act. The net impact of these provisions which affect outlays rather than revenues is unlikely to be large compared to the impact of the provisions estimated. Low-income vouchers are excluded because the outlays are approximately equal in size to reductions in federal grants to the states for Medicaid.

b. Includes repeal of deduction for health insurance premiums.

Mr. GEPHARDT. Thank you very much.

Thank you, Mr. Chairman.

Chairman JACOBS. If there are no further questions, we express our gratitude again, Dr. Rivlin, to you and Dr. Ginsburg.

Thank you for your appearance.

Ms. RIVLIN. Thank you, Mr. Chairman. If we can be of further assistance, please let us know.

Chairman JACOBS. We will come over. Thank you.

The next is a panel, Clark C. Havighurst and Paul M. Ellwood, Jr.

Mr. Havighurst is professor of law at Duke University; Dr. Ellwood is president of InterStudy.

STATEMENT OF CLARK C. HAVIGHURST, PROFESSOR OF LAW, DUKE UNIVERSITY

Mr. HAVIGHURST. Mr. Chairman I am Clark Havighurst. I teach antitrust and regulated industries law and seminars in the health care field at the Duke University School of Law. I have been writing about the health care industry since the 1960's and have been a believer in competition as a solution to the health care industry's problems since Dr. Ellwood introduced me to the HMO concept way back in 1969. I have submitted a prepared statement and apologize for its length. It is literally a case of not having had enough time to write a shorter statement. The statement reflects views that I have written about at greater length in a book that is due out this winter.

In these remarks I want to spell out some of my ideas about the kinds of reforms that are needed to make the health care industry satisfactorily competitive. I have a somewhat different view than some other proponents of competitive solutions, and the difference is mostly that I visualize a somewhat more limited role for Government than appears in Professor Enthoven's consumer-choice health plan or in Mr. Gephardt's bill. These views may bear some resemblance to the views that the administration may eventually arrive at. They have a ways to go, I gather, but I expect that my more laissez faire attitude and my more piecemeal approach to the problems may turn out to be somewhat similar to their approach.

I think there are essentially two policy moves that are needed to instill appropriate cost consciousness in the industry. Increased cost consciousness on the part of consumers will stimulate competitive innovation in private financing mechanisms, and the emerging reforms will, in turn, stimulate price competition among providers. It is this process that perhaps Mr. Rangel was seeking to have explained a minute ago. The idea is simply to get those engaged in the insurance business, or in organizing competing delivery systems, to compete among themselves in containing costs. In order to compete and to keep their costs down, they would have to bargain with the providers of care and force the providers into competition over price and over their willingness to cooperate with cost-containment measures that the plans attempt to implement. By changing the basic incentives to reintroduce cost consciousness, you can start that process going. That is what underlies the competitive strategy; that is the goal of it.

The first essential step, it seems to me, is a change in the tax subsidy for employer purchased health insurance, which Ms. Rivlin discussed. The reasons for making this change are now, I think, quite clear. The subsidy for the purchase of health insurance distorts demand for insurance, and the presence of insurance then distorts the demand for care. To the extent that people buy broader or more liberal coverage than they would otherwise buy, we have succeeded in inducing inappropriate demand for services. Consumers do buy broader coverage. They insure things solely because that is the way to get a tax break. People buy insurance not to protect themselves against financial hardship but to exploit a tax loophole.

Dr. Ginsburg has done some estimates that indicate that if you pay for a service through insurance instead of out-of-pocket, you get a discount of about 43 percent on the price of that service. This figure was derived by taking the average marginal income tax rate of 31 percent and adding it to the social security tax rate of 13 percent, giving a figure of 43 or 44 percent. That figure, thus, reflects the marginal tax rates as they used to be, not as they are under the new tax law. I have not seen a new number on that, but presumably it is around 40 percent. That discount is a strong inducement to insure; and once people are insured, they don't care what the cost is. The discount then may be as much as 100 percent.

With an open ended tax subsidy, health insurance plans provide less disincentive to consumer services than they otherwise would. Thus, they reflect the tax law's penalization of all kinds of out-of-pocket payments including cost sharing. For similar reasons, employers' efforts to contain costs are discouraged because the benefits to the consumer are not as great as they would be if the consumer could keep the entire saving as wages. Instead he pays taxes on it. Thus, a dollar saved here represents less than a dollar earned.

It seems to me that it is now pretty obvious that limiting the tax subsidy is essential so that employers and employees will be spending their own money, not the Government's money, on marginal health benefits. Once they are paying their own way in a free and unrestrained market, it seems to me that Government will no longer have any real basis for second-guessing the choices they make. Once they are spending their own money, spending in the private sector could be deemed to reflect consumer preferences, and there would be no bases left for regulating private health care costs. Indeed, there would be no bases for saying that there is a problem about health care costs in the private sector, because those costs would reflect decisions by consumers to pay those costs. The presumption would have to be that they think they are getting their money's worth. That is not a decision that the Government would have to make.

I am not going to discuss precisely how the tax laws should be changed. I favor a national limit on the amount of the employer contribution that is excludable from the employee's taxable income. I think that limit should be set at a level that would force a substantial proportion of the employed population to immediately reevaluate their coverage in terms of whether the marginal dollars spent on coverage are giving them something worth the cost—the after tax cost. I suggest that Congress should seek a tax change that would cause at least half of the employed population to reconsider their purchasing practices.

Mr. Chairman, there is no real excuse for not moving on this front pretty soon. It doesn't seem to me that the tax change has to be in the same bill that deals with the other problems that I will address. I would hope that this would be something that could be acted on without delay.

A second essential step is, of course, to introduce the principle of cost-conscious choice into public programs. Dr. Ellwood will discuss this particular measure with you. The model for letting public beneficiaries exercise choice in the private sector would presumably be something like those proposed by Mr. Gephardt and Professor Enthoven. This is a Government-structured system of choice. That is how I like to describe it: a system of choice that the Government sets up and offers to people. It seems to me it would work pretty well for public beneficiaries and for those who don't have employer-based coverage.

I would like to go on record, however, as not favoring the use of that model in place of employment-based group insurance. It seems to me that, if we adopted a Government-structured system for all consumers, it would be unavoidably and excessively regulatory. Because of the large number of choices that would be available to consumers, the Government would feel the need to simplify choices by limiting the options, setting minimum benefits, controlling the amount of cost sharing, and controlling other aspects so that the consumer would not be confused. There would also be a strong temptation to regulate so that no option would be offered that would be inappropriate for any offeree, again limiting the range of choice. Regulation also would be used to curb the problem of self-selection, which I find an almost impossible job. I would prefer to rely on a private insurance market in which people pool their health risks with those who have like risks and to deal with the problem of uninsurables in other ways. I believe that it is a mistake to try to convert private insurance into social insurance in the process of trying to establish a Government-structured system of choice.

The group insurance market, on the other hand could be left quite unregulated. That, in turn, would allow extensive innovation to occur without the Government having to approve every innovation that might be tried. The States have not felt the need to regulate the private group health insurance market, and their decision is both sound and fortunate. The full range of desirable options will develop only if Government is not left in charge of the system.

Another proposed regulatory move that I would recommend against is the proposal to require employers to offer their employees a multiple choice of health plans. Multiple choice can be offered voluntarily by employers, and it seems to me that it would be in their interest to offer it in many cases. I would expect many employers to offer options as a way of letting the employees engage in economizing that the employers themselves have been unable to engage in because the employees don't see the savings. Using multiple choice gets the employer off the hook for any seeming shortcomings in the plan. Once the employee does the economizing—

benefits himself from making an economizing choice—he can be held to have accepted the somewhat limited coverage he may have obtained.

Offering multiple choice would break down the entitlement mentality that surrounds so many private employers' health plans. The problem that the employer faces is very much the same entitlement mentality that Government currently faces, in trying to economize. Introducing choice is a way of escaping the final responsibility for choosing for other people and letting them choose for themselves. The idea is equally valid for both employers and Government.

If employers don't offer multiple choice voluntarily and continue to buy the kinds of coverage we think is excessive and wrong, it still seems to me that we have no case for compeling them to offer multiple choice. Even if you did compel them to offer multiple choice, it is not clear that the result would be particularly desirable since employers wouldn't offer reasonable choices or assist the employees in choosing. Instead, they would find ways to satisfy the requirement without offering meaningful choices or doing the careful screening that is contemplated. Government thus would be tempted to regulate more by prescribing choices and so forth. It seems to me that the benefit isn't worth the cost in heavy regulation.

Most important, as I said before, it shouldn't be Government's concern if employers and employees choose to spend their own money unwisely. Once the tax law is changed, it seems to me that we can treat employers' and employees' decisions as their own. If the employees' interests aren't being served by their employer or union, that is between them and the employer or the union. It is not a problem that Government should be concerned with.

Although Government may have an interest in expanding markets for innovative health plans in order to encourage innovation, that interest could be served without regulating employers. Instead of mandating multiple choice, Congress could give a one-time tax credit for employers who give a multiple-choice option to their employees—in other words, a credit of so much per employee offered multiple choice between now and, say, 1984.

With the tax law changed and consumer choice introduced in public programs, Government would only have a few more things to do, to complete work on the market strategy. In particular, only two things need to be done to insure that the competitive process operates successfully. First, we need to enforce the antitrust laws. It seems to me we are progressing rather well on that front and that no legislative changes are needed.

Second, we need to pay attention to the regulatory programs that are in place in this industry and establish a framework for substantially deregulating the industry. My recently completed book argues that the 1979 amendments to the Federal health planning legislation can serve as such a framework if their procompetition provisions are given their full effect. Deregulation also requires that we consider ways of inducing changes in State laws that interfere with the carrying out of a procompetitive Federal policy. The Federal Government must be willing to preempt some State laws that get in the way of competition.

The remaining policy changes that are needed to round out the market strategy involve correcting for some important market failures which occur in this industry and which need to be addressed. Although these moves are not necessary to get the competitive process started, they are essential features of a proper procompetitive policy just the same, because, unless these market failures are addressed, the market will not work well and we would be disappointed in the outcome.

Let me list three problems that I think need to be addressed specifically in this category. The first is the need to assure adequate catastrophic coverage. I would support a regulatory proposal to force private employers to provide catastrophic coverage in their health plans. The purpose of regulating is quite narrow, however. The problem is that people are apt to underinsure against catastrophic risks and to rely on the system to take care of them if they should happen to suffer a calamity. Under intensified competition, the system would be less able to bear the burden of such free riders. Although there is a good argument for regulating in this area, care must be exercised not to draft the regulatory requirement in such a way as to reopen the door to the bank, permitting providers, once they get across some catastrophic threshhold, to run up the bill in an unlimited way. Adequate coverage need not be unlimited. Congress should remember that the goal is merely to solve the free-rider problem, not to prevent all possible financial hardship.

The second point I want to emphasize here is the need to replace lost subsidies for education and research. A serious side effect of competition would be to deprive the academic medical centers of the revenue that they have relied upon in the past to support these socially advantageous activities. Previously, they have included the costs of these activities in their charges to insured patients and in reimbursable costs, but under competition, those revenue sources would no longer be available. It does seem to me that Government has a responsibility to recapture some of the savings that consumers will enjoy under competition and give it back to the centers that do important things in the area of education and research.

Finally, there is the problem of poor people, who have also benefited from cross subsidies in the past—that is, from the willingness and ability of some institutional providers to provide care without compensation and to recover the costs of that care by overcharging others. Again, in a competitive world those overcharges will not be possible. It does seem to me we have to find ways of replacing the hidden subsidies that would be lost with new and explicit ones. I think that if the competition strategy is pursued without specific early attention to this problem, we could be quite distressed at some of the hardships that would be caused. I believe that provisions for offsetting some of the squeezes that competition will place on the system must be made on integral part of the procompetition strategy.

Chairman JACOBS. Dr. Ellwood.

Dr. ELLWOOD. Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF CLARK C. HAVIGHURST, PROFESSOR OF LAW, DUKE UNIVERSITY

Mr. Chairman, my name is Clark C. Havighurst. I am a professor of law at Duke University with academic interests in the field of antitrust law and economic regulation of business. Since the late 1960s, I have written extensively on health care issues, documenting in various ways my view that the potential of government regulation for dealing with the problems of the health care industry is greatly overestimated and that the potential efficacy of market forces and competition has been seriously underestimated. It is naturally gratifying to me to see that policymakers are now seriously considering ways to strengthen market forces in the health care industry. I particularly appreciate the opportunity to participate in these hearings. My comments here are a summary of views that I have expressed at much greater length in a recently completed book entitled Deregulating the Health Care Industry: Planning for Competition. This book is to be published around the end of the year by Ballinger Publishing Company, Cambridge, Massachusetts.

Some Historical and Political Background

Let me begin with some historical background showing where the idea of competition came from and why it currently enjoys some policymakers' support. As recently as 1978, competition was almost exclusively an academic idea, and the conventional wisdom was that government, one way or another, would have to control health care costs through regulation. Competition was simply a code word for encouraging HMO development as part of a pluralistic but still largely noncompetitive system. The fee-for-service sector itself was viewed as immune to internal price competition and also as being able to weather a great deal of HMO competition without having to change its spendthrift ways. This imperviousness to competition was deemed to result from providers' presumed ability to create their own demand. The Carter administration, viewing the challenge as one of designing regulation to curb these cost-escalating tendencies, came up with its hospital cost containment bill in 1977. Even though it was a logical extension of the trend toward regulation, that bill to limit arbitrarily the growth of hospital revenues never made it through the Congress.

Assumptions about the inevitability of regulation began seriously to break down in 1979 when the 96th Congress convened. With its defeat of the Carter cap proposal in late 1979, Congress effectively seized the policy initiative from DHHS, which had nothing left to offer once the centerpiece of its program was lost. Several individual members of Congress moved into the resulting policy vacuum, including Congressman Ullman and most of the leaders in the congressional fight against hospital cost containment. Even though the defeat of that legislation was widely credited to effective industry lobbying, in fact it owed a great deal to the willingness of Congress, first, to think through the full implications of further pursuit of regulation and then to recognize a market-oriented alternative to the kind of heavy-handed regulation that the Carter proposal contemplated. Thus, the leaders in the fight against the Carter bill, particularly Congressmen Gephardt, Stockman, and Jones and Senators Schweiker and Durenberger, took seriously their responsibility for coming up with an alternative solution to the cost problem and subsequently sponsored bills to reform the health care marketplace. In addition to these substantial contributions to the appearance of the market strategy, the 96th Congress also enacted the health planning amendments of 1979 (Public Law 96-79), which included the first legislative endorsement -- and a surprisingly strong one at that -- of competition as a potentially valuable force in the health care field.

The emergence of the competition strategy was probably inevitable, even though few people foresaw the force with which it would enter the policy debate. The movement toward deregulation in other industries should have indicated that it was just a matter of time before Congress's right hand would realize what its left hand had been doing to the health care industry. Moreover, it should have been obvious that the new forms of regulation needed to achieve effective cost control in the health sector would be intolerably arbitrary and insensitive, systemetically evading (or shifting to providers)--the difficult choices which are necessarily involved in rationing but which government cannot afford to face on a case-by-case basis. At the same time, the arguments for competition were gaining force as a result of able advocacy, particularly the appearance of Alain Enthoven's Consumer-Choice Health Plan, which, as a tangible program that people could contemplate, gave concreteness to what had previously been only an abstract theory and helped to shift the debate away from an exclusive focus on HMOs. The continued, if moderate, success of the HMO movement, together with publicity given to experience in the Twin Cities and elsewhere, also helped to advance the flag of competition in the public debate. Finally, the antitrust enforcement effort and the FTC's emergence as the first liberal advocate of competition -- and its first advocate of any kind within the federal establishment -- gave competition new credibility and respectability.

Subtle changes in public attitudes toward health and health care have also contributed to the competition strategy's emergence. The increasing emphasis in recent years on personal responsibility for one's own health has coincided with the reduced frequency of references to the idea that "health care a right." One implication of this shift in attitudes is greater acceptance of the idea that people can be expected to bear some of the cost of their own health care and can be allowed to make cost-conscious choices. Evidence that health services vary widely in their efficacy and cost effectiveness and that personal health care is not the most important contributor to improved health status has likewise increased tolerance for diversity and consumer choice.

Yet another factor that brought competition back into the policy debate was the disappearance of the more extreme models of national health insurance. Because early proposals contemplated that government would serve as the great third-party payer, health policy concentrated on perfecting government's tools for policing the system and neglected private financing mechanisms and consumer choice, which were seen as vestiges of the past shortly to be displaced. Thus, the policy agenda changed dramatically when Senator Kennedy and the labor movement agreed in the mid-1970s to accept a role for private health insurers as well as HMOs in the projected national health insurance system. Suddenly it became necessary to consider how to get good performance from the private sector, and competition was undeniably a viable contender for a substantial role in that effort. Indeed, once the issue was posed in this way, competition began to look quite promising in comparison to regulation.

The advent of the Reagan administration appears, of course, to have increased the chances that procompetition legislation will ultimately be enacted. Obviously, the proponents of market-reform bills have moved into prominent positions, and there have been several expressions of a commitment to pursue the strategy actively. It is worth noting, however, that the competition strategy was already established in Washington before the Reagan administration came to town and had a great deal of momentum behind it. It is not exclusively a Republican initiative. Indeed, although DHHS in the Carter years would not hear of these ideas, others in the Carter administration took a substantial interest in them. In particular (though he was not alone), Alfred Kahn, the patron saint of deregulation, was vigorously promoting the competition strategy when the Carter administration left office. There are many other signs that the market strategy could turn out to be a bipartisan effort. Indeed, as they did with deregulation, the Democrats might ultimately make this initiative their own. In some respects, they might prove more capable of carrying it out in a responsible way, by paying adequate attention to some of the side effects that the administration may be inclined to neglect. Just as only a Republican administration could open the door to China, perhaps only the Democrats will eventually be able to carry out a fully developed market-oriented policy in health care.

Even though the political climate now seems hospitable to a market-oriented national health policy, government may not be able to follow all the way through in implementing a procompetitive strategy. The antagonism to regulation that one senses is not the same thing as favoring aggressive efforts to rehabilitate the market as a force for changing the status quo. Indeed, a philosophical commitment to reducing government's role could easily undercut such necessary measures as antitrust enforcement and the provision of new public funds to replace desirable internal subsidies eroded by competition. Similarly, a philosophical propensity to return responsibilities to the states invites the continuation of regulatory patterns and state-supported professional controls that have long diminished competition's force. Finally, government has great difficulty in pursuing any goal singlemindedly through the thickets of special interests. Recent history suggests that the federal government has great difficulty in settling on a coherent and internally consistent national health policy and implementing it on all fronts. I am not yet persuaded that the nation has the leadership necessary to act forthrightly and consistently on this extremely important subject.

The Thesis Underlying the Market Strategy

The market strategy involves simply changing consumer incentives and widening opportunities for consumer choice. The ultimate goal is to force providers to compete more actively than they do at present on the basis of both price and their individual willingness to submit to organized health plans' various cost-reducing measures. The thesis connecting the chosen means to this projected goal is that increasing consumer cost consciousness will increase competitive pressures, first, on private financing mechanisms and, through them, on providers, and thus will significantly change behavior throughout the system in desirable ways. Many observers express doubts that enhanced competition under appropriate incentives will in fact bring about material changes in health care financing and delivery that will actually help in controlling costs. While I have great confidence that substantial changes would occur, the question that I regard as more relevant is the feasibility of establishing a process that effectively reveals consumer preferences and induces providers and others to serve them. Once such a process is in place, the market's verdict should be accepted as an expression of people's wishes. If people are spending their own money on health care coverage and are not subsidized by government beyond some basic minimum level, it should no longer be a concern of government that they choose to spend their money one way rather than another. Even if spending levels and patterns should turn out to be no different than they are today, one should not conclude that the market strategy has failed. Cost reduction per se is not the objective. Instead, government should seek only to give consumers the opportunity to express their preferences in an undistorted and responsive marketplace and should accept the results of that competitive process.

The key elements that must be addressed in the market reform bills include, on the demand side of the market, the incentives of consumers and those who act as their agents in selecting or designing financing arrangements and in bargaining with insurers or providers. Also on the demand side, there are innumerable issues surrounding the manner in which beneficiaries of public financing programs can be motivated and permitted to economize without jeopardizing the objectives of those programs. On the supply side of the market, freedom to enter and to innovate must be assured so that the range of choice available to consumers is not unreasonably constricted. In my view, the causes of the current problems in the private sector include open-ended tax subsidies for employer-purchased health insurance, provider-imposed restraints on innovation and cost-containment initiatives, and employers' and unions' questionable representation of employee interests in purchasing decisions. The thesis of the policy discussion below is that these problems, as well as the additional complexities introduced by government financing and regulatory programs, are all amenable to effective governmental action.

The following discussion considers what I regard as the primary problem of national health policy, namely how to get market conditions so that they encourage private sector adaptation to consumer cost concerns. On the demand side of the market, private purchasers' distorted economic incentives can be corrected by a change in the tax law, and public program beneficiaries can be offered new opportunities for cost-conscious choice. At the same time, the supply side's freedom to offer a full range of choice can be fostered by vigorous antitrust enforcement. Whether, if these things are done, anything else is necessary or desirable, is an open question to which much of the discussion below is addressed. Most of the major proposals seek to assure that all consumers have cost-saving options available to them by having government maintain, or by requiring employers to maintain, a structured system of consumer choice. The discussion below raises some doubts about these proposals except insofar as they would enhance the opportunities for cost-conscious consumer choice by the beneficiaries of public programs and by others falling outside the market for private group coverage.

Changing the Tax Treatment of Employer-Paid Health Insurance Premiums

A crucial element in the procompetition proposals is a change in the tax subsidy for employer-paid health insurance. Reliance on market forces is justified only if those forces are pulling us where we want to go, and there would be good reason for doubts about strengthening competition in a market where subsidies cause purchasers substantially to underestimate the cost of everything they buy. The problem is particularly acute in respect to subsidies for the purchase of health insurance, since, once purchased, the insurance plan subsidizes the consumer entirely to the full extent of his coverage. Thus, it is extremely important that cost consciousness operate in the purchasing of insurance in order that individual plans will be under competitive pressure to keep their respective costs down by limiting coverage to essential services and by bargaining with providers over utilization, fees, and charges.

The current tax law excludes employer-paid health insurance premiums from employees' wages subject to income and Social Security taxes. Although the subsidy is generally greater for upper-bracket taxpayers and minimal for low-income persons with little tax liability, taxpayers across a very wide spectrum enjoy a very large discount for all services purchased through insurance (with untaxed dollars). Paul Ginsburg has estimated that (under the old tax rates) taxpayers enjoy an average discount of 43 percent for all services paid for through an insurance plan. The tax penalty for out-of-pocket payments induces people to buy more extensive coverage than would otherwise be desirable and to eschew cost sharing that might help to contain costs.

Because health insurance is now valued not only as a means of obtaining essential financial protention but as a vehicle for obtaining federal help in paying routine bills, the demand for insurance is greatly distorted. This distortion in turn induces a broader distortion in the demand for services. It encourages excessive liberality on the part of insurers in the payment of claims, less than optimal use of dollar limitations on indemnity payments, and an undue preference for paid-in-full service benefits. By the same token, cost-containment efforts by third parties are not valued as highly as they should be, since any saving in premiums that is achieved and paid out as increased wages becomes taxable income. Insurers have thus been unduly passive in dealing with providers. The tax subsidy has also induced many employers to bear the entire cost of health insurance and not to require employee contributions, at least for individual coverage. Employees have thus been rendered unconscious of plan costs and lulled into an entitlement mentality. Cost-saving initiatives are much more difficult under such circumstances.

This recitation should make clear why the tax subsidy for private health insurance should be limited. With consumer incentives to economize appropriately strengthened, private initiatives could reasonably be expected to move toward efficient levels of spending on health care. Obviously, overall allocative efficiency would also require redesign of public programs, but that redesign should be easier if pressures from newly cost-conscious bulk purchasers of health coverage and self-supporting consumers have already stimulated competition in insurance and provider markets. Thus, Congress should give immediate attention to triggering this impetus for change. The resulting innovations in private financing mechanisms would pave the way both for comparable administrative changes in public programs and for greater reliance in those programs on consumer choice. Moreover, greater efficiency and competitiveness in the larger market might facilitate expansion of public programs by freeing resources to meet, and reducing the cost of meeting, currently unmet needs.

I do not propose to discuss here the specific ways in which tax exclusion should be limited. I strongly believe that the matter should be approached directly and that a single nationally uniform cap should be placed on the exclusion. While this could be characterized as "a tax on health benefits," it is really the elimination of a highly undesirable tax subsidy and loophole. Various adjustments could be made to affect the incidence of the tax change, and there are important revenue effects that, particularly in the present budgetary situation, must be considered in deciding which approach should be adopted. The key objective should be that, beyond some fixed point, the marginal dollars spent by an employer on health insurance would have the same after-tax value to employees as dollars paid in wages. While there are difficult decisions to be made and serious technical problems to be overcome, surely these are matters that Congress can successfully resolve.

Mr. Chairman, I hope that political difficulties and technical complexities will not deter the adoption of a tax measure that heightens the hitherto suppressed economizing incentives of a critical mass of consumers. In addition to promoting allocative efficiency by facilitating unbiased expressions of consumer preferences, such a tax change would stimulate a needed reevaluation of employee health benefit programs. That rethinking would in turn prompt competitive responses in the private insurance market and among providers. A useful rule of thumb for evaluating tax change proposals would be whether at least half of the employed population would be placed in the position of having to reconsider the value of their marginal purchases. Another goal should be to assure that basic medical and hospital coverage, and not just dental and other similar insurance, are reexamined.

It would be unfortunate if, in pursuing these immediate goals, policymakers should lose sight of the attractive possibilities for using the tax law to assure virtually universal basic coverage in the entire self-supporting population (including those lacking access to coverage through an employment group). By providing taxpayers a limited tax credit or exclusion for premiums paid to plans providing at least satisfactory catastrophic coverage, one essential goal of national health insurance could be readily achieved very soon. Ultimately, refundable tax credits, perhaps payable in advance to solve cash-flow problems, might serve as vouchers allowing low-income persons to participate in private health plans at public expense. One must hope that the expedient tax changes to be made now in order to straighten out the incentives of the employed population will be designed so as not to foreclose such future steps to assure universal cost-effective coverage. Professor Enthoven's plan and the Gephardt-Stockman bill provide helpful models for extending limited tax subsidies to underinsured populations when it is fiscally possible to do so.

The Respective Roles of Government and Employers in Structuring Consumer Choice

Market reform proposals differ in the extent to which they contemplate the continuation of employer-based insurance. Professor Enthoven's proposal and the Gephardt-Stockman bill look ahead to a day when employers would have no role in the design or selection of their employees' health plans, which would instead be chosen by individuals from a government-sponsored array of private plans. Other proposals would preserve some employer decisionmaking (and thus also collective bargaining) with respect to health benefits but would narrow the employer's discretion or limit the employer's ability to make the final choice. Thus, some proposals contemplate regulation of the health plans' content, whereas others would structure things so that employers and unions would be responsible for providing a menu of choices ("multiple choice") but the final choice from that menu would be made by the individual employee. Thus, a critical issue is the relative roles of government and employment groups in the selection of health care plans.

It is my view that employers should be left free to play a major role in choosing or structuring choices without substantial regulatory restraint and that government should assume a consumer-protection role only with respect to the market for individual, as opposed to group, coverage. Government structuring of the choice system would invite heavy regulation. Because consumers find it difficult to make fully informed choices among numerous complex insurance plans, government would feel the necessity to limit the extent of differences among plans so as to simplify choices and so that no consumer would make a substantial mistake. Uniformity of benefit packages and comprehensive coverage would be preferred, both to facilitate comparisons and to minimize the problem of adverse selection that arises when benefits differ. Direct regulation requiring community rating and open enrollment would also be introduced to prevent adverse selection and to force healthier individuals to bear the costs of those less fortunate. In general, I am concerned that a government-dominated system of choice would so limit the range of choice and impose so many regulatory controls that innovation in health care financing would be unduly restricted.

It is possible that enough innovation and variety is possible within the HMO framework and without departing from comprehensiveness in benefit packages that the problems I worry about would not materialize. Nevertheless, I see too many opportunities for innovation that would probably be foreclosed in a government-structured system of choice. Consequently, I am strongly drawn to the model of a true free market in group insurance in which employers act as consumers' agents in purchasing coverage or in structuring their choices. In my view, government's role should be limited to subsidizing the purchasing power of those who need it and managing a structured choice system for those who lack opportunities to purchase through an employment group.

The Enthoven and Gephardt-Stockman proposals have materially advanced understanding of health policy choices and the role of competition. Nevertheless, my analysis suggests that, contrary to those proposals, government is not the best vehicle for structuring consumer choice and minimizing consumer ignorance. Because most consumers have access to better assistance in procuring the financial protection most appropriate to their personal circumstances, government should allow these alternative mechanisms -- primarily group purchasing through employment groups — to operate. I reach this conclusion despite my recognition that employers and unions have not been wise purchasers in the past. Nevertheless, with a change in the tax subsidies that have influenced their behavior so profoundly, I would expect fundamental rethinking of the health benefits plan in employment groups and a shift to greater emphasis on individual choice. As indicated below, however, I have also concluded that mandating multiple choice is not a desirable regulatory move at this time, though it would be appropriate if a substantial tax change were not enacted.

The key insight here is that employers and unions can achieve economies of scale in searching the market and bargaining with health plans while avoiding some of the diseconomies of larger scale and political organization that appear to limit government's ability to serve in the same choice-screening capacity. They are also in a position where they can either make the final purchasing decision on the employees' behalf or perform the service of structuring the individual employees' choices so that inappropriate options are excluded and the remaining options are carefully explained. The latter role, while still unfamiliar, is closely analogous to the role visualized for government in the Enthoven and Gephardt-Stockman proposals but seems more promising. Whereas government must maintain a lengthy and therefore inherently confusing menu of plans for individuals to choose from, employers can limit the number of choices, selecting them with care from a larger universe but leaving the individual to make the final choice. Paradoxically, this unique ability to offer fewer choices selected in a competitive environment allows the employer to offer the consumer, safely, a wider range of choices than government would probably see fit to make available. Quite simply, the consumer who is offered only a few preselected and well defined options in an environment where he can share experiences with co-workers would be less handicapped by ignorance than the individual participating in a government-structured system of choice. No better proof of this assertion is required than experience under the Federal Employees Health Benefits Plan. Despite the Office of Personnel Management's extensive disclosure requirements, almost any federal employee -- including some who are health care experts -- will admit to being mystified by the choices available. A private-employer-sponsored system of structured choices promises material improvement.

The argument for mandatory multiple choice would be that it would force all employers to assume the choice-structuring functions contemplated in the foregoing paragraph. Unfortunately, I conclude that multiple choice, while it should be strongly encouraged, should not be made mandatory. The reasons are several. First, it occurs to me that employers will have a strong incentive to adopt multiple choice voluntarily in order to escape ultimate responsibility for the content of the plan. Because employers have found that economizing moves are misunderstood by employees, a shift to individual choice, whereby employees do their own economizing and benefit themselves in so doing, would seem to be highly desirable from the employer's point of view. Because extending economizing opportunities to individuals is a strategy that employers and unions could adopt voluntarily, I would be content with changing the tax incentives and counting on many of them to do so.

The case for mandating multiple choice rests largely on perceptions of employers' and unions' past performance and does not adequately allow for the possibility that a change in the competitive environment and in the operative incentives will be sufficient to induce the desired behavioral changes. As long as provider-imposed restraints of trade prevented the market as a whole from offering meaningful alternatives, multiple choice made little sense, and employers can hardly be criticized for not having adopted it and for falling instead into the present pattern. Now, however, with antitrust enforcement and increasing cost pressures, new options are appearing in many markets, and some employers are showing signs of responding to these new opportunities. A tax change that raised the cost of marginal health coverage for a majority of workers would surely stimulate many more employee benefits managers to reconsider their options.

Once employers and employees were jointly spending only their own money on marginal health benefits, it could be strongly argued that government should ignore any remaining problems and should not intervene further by mandating multiple choice. While I would expect that employers would soon find it advantageous to offer multiple choice and to encourage individual economizing, any failure by them to act in their own or their employees' interest would be a problem between them and the employees and not a matter that government should concern itself about. As I emphasized earlier, government's job should be to make sure that the market makes a full range of choices available and that demand is not distorted by inappropriate subsidies. Regulation to force employers and employees to act in their own best interest seems unnecessary and undesirable.

Mandatory multiple choice would also not achieve the desired effect. An employer who introduces choice only in response to compulsion is unlikely to perform his screening and choice-structuring role in a manner helpful to his employees. If government thought that employers were not performing their function adequately, it would be tempted to go further and to specify particular options that must be made available. Thus, we would fall once again into a regulatory mode, with government specifying the content of health plans and displacing the private market and private decisionmaking.

Yet another problem with mandating multiple choice is that some employers may find it very hard to adopt it in a useful way. The adverse selection problem would be very real in an employment group, and offering really meaningful choices would probably induce risk selection that is costly to the employer. Thus, if all low-risk employees congregated in a low-option plan and received the difference between that plan's premium and their per capita share of the employer's total contribution, they would enjoy a considerable windfall at the employer's expense. At the same time, the employer would be under pressure to contribute enough on behalf of higher-risk employees to cover the higher premiums with which they would be faced. While employers could solve these problems in a variety of ways, the solutions would not be easy, and employers would thus be justified in resisting politically any proposal to mandate multiple choice even if they might adopt multiple choice voluntarily in some form once they perceived that it was in their interest to do so.

In view of these problems, mandating multiple choice would amount to unnecessary overregulation. Nevertheless, in view of (1) employer recalcitrance in recognizing the potential value of multiple choice, (2) the costs of shifting to multiple choice, and (3) the desirability of increasing the market opportunities of innovative health plans, I would think that government should consider subsidizing the employer's installation of a multiple choice system. Thus, an employer might be allowed a one-time tax credit for each employee offered meaningful multiple choice within the relatively near future -- say, by 1985. This would seem a more appropriate way than regulation of stimulating what is obviously a desirable shift.

Public Programs Reforms

Although changed incentives for private purchasing of health care coverage would trigger the process of innovation, the large volume of services rendered at government expense would be affected only indirectly, if at all. Indeed, the net effect of increasing stringency in private programs would be harmful to public programs if providers sought to maintain their incomes by exploiting the public programs more than ever. Not only to protect the public pocketbook against new exploitation but also to assist in stimulating supply-side innovation, the federal government and the states should begin adapting their programs to fit the larger procompetitive policy. Whether the initial procompetitive changes in the Medicare and Medicaid programs should be made in the same legislative package as the tax law amendments would depend on political strategy, but it could be counterproductive to try to solve all of the health sector's current problems in one legislative stroke. It might be preferable to seek prompt enactment of the tax-change legislation as a sign of the new policy emphasis and to proceed to deal with the more complicated Medicare and Medicaid programs independently, though as expeditiously as possible.

I do not intend to spell out here a program of specific changes in Medicare or Medicaid or to specify the structured consumer-choice system to which the federal government might ultimately move in order to offer choice and appropriate subsidies to populations that lack access to private group coverage. Obviously, fundamental changes will require a great deal of thought. Professor Enthoven has recently proposed a far-reaching plan under which current Medicare beneficiaries would be offered a chance to opt out of the basic program, which would be phased out as that population dwindles; new beneficiaries would have to choose a private plan in a government-structured system of choice under which open-enrollment and community-rating requirements would assure universal coverage. This method of phasing in a new system would seem to have much merit. Moreover, if feasible, the use of regulation to protect consumers against mistakes and to assure universal coverage for the elderly would not be subject to as many objections as a similar system covering the employed population; although there would be some hidden cross subsidization, most of the money would come in the form of explicit subsidies.

There are a few reasons why Congress might be reluctant to enact legislation along the lines of the Enthoven proposal. Cashing out the Medicare program entirely into a voucher-type system (as the Enthoven proposal would do for new beneficiaries) would impair the program's basic and politically important entitlement character; arguably (though not obviously), it would be easier for a future Congress to reduce the cash value of the vouchers than it has been for it to reduce benefits in the past, thus causing beneficiaries to worry that the program's value to them will erode under budgetary pressures. On the other hand, if the basic Medicare entitlement program were kept in place as an available option (which the Enthoven proposal would do for current beneficiaries), the federal government would face an adverse-selection problem similar to that faced by an employer implementing multiple choice. Thus, the government would want to be sure that it could assign actuarially correct values to the vouchers so that only efficient plans could give more benefits for the voucher than the basic program; otherwise, the government's total cost could rise substantially solely because of adverse selection.

With respect to the Medicaid program, some problems are raised by the current interest of the administration in shifting more of the cost burden to the states. A corollary policy is the granting to the states of relief from some federal requirements that have limited their flexibility in controlling costs. A hopeful possibility is that this new flexibility will encourage the states to employ such innovative procompetitive techniques as paying providers on the basis of negotiated prices rather than costs and limiting beneficiaries' freedom of choice so as to exclude high-cost providers. Ultimately, some states, overcoming concerns about the higher costs that might arise from adverse selection, might let beneficiaries enroll at state expense in competitive health care plans. Despite these possibilities, the greater likelihood is that most states will simply reduce benefits and eligibility. Moreover, states might simply tighten their regulatory controls over the system as a whole, threatening the success of the larger market strategy. For these reasons, Medicaid reforms should not be left entirely to the states.

It is important that efforts to restructure public programs be undertaken with sensitivity to the important social values at stake and not with an eye solely to economizing on public expenditures and promoting competition without regard to its side effects. Unfortunately, as noted below, needed restructuring of public subsidies, if responsibly undertaken, will probably result in government's incurring some new direct costs. Responsible political leaders should recognize, however, that some of the savings that self-supporting consumers derive in a competitive system are properly appropriated to cover the costs of improved public programs. Even if government is unimpressed by high-minded reasons for making new funds available for public programs, perhaps the need to reassure providers concerning the impact of procompetitive policies will force attention to these issues.

It is possible that the perceived complexities involved in developing a universal voucher-type system of structured choice for public programs will make piecemeal measures to establish the feasibility of the concept seem to be all that is currently feasible. Demonstrations, some of which are already under way, should not be undertaken as an excuse for delay, but, if further experimentation is deemed necessary, it should be clear that the goal is to determine how -- and not whether -- to run a market-oriented public financing plan. In order to make sure that the right message is given to the private sector, there should certainly be an immediate departure from the anticompetitive principles of assured cost reimbursement and unlimited free choice of provider for public beneficiaries. Thus, "prudent purchaser" strategies should be adopted, and various other incentive mechanisms, perhaps including the preferred-provider approach, should be tried. An important goal should be to convince the private sector that the days of cost reimbursement are numbered and that competitive purchasing and bargaining can be expected to increase. There exists no surer way of curbing the health care system's historic propensity to grow without adequate regard to supply and demand conditions. Moreover, the threat that public programs will increasingly exercise their concentrated buying (monopsony) power should make providers much more receptive to the idea of installing a voucher-type system of structured choice.

Items on the Unfinished Federal Agenda

With the tax subsidy for private health insurance appropriately limited, with the principles of competition and choice introduced in public programs, and with the supply side of the market free, under antitrust protection, to respond to the new demand for economizing, the federal government would have only a few more things to do to put the health services industry on a permanent competitive footing. While everything discussed under this heading is extremely important, none of the recommended actions is a prerequisite to substantial success in stimulating competition and private innovation. In this sense, the identified agenda items are loose ends that, though they must be tied up soon, are not as urgent as the tax change and the initiation of public program reforms. Some of the measures recommended here address residual incentive problems that result from minor, though ultimately important, market failures. Others are needed to offset some predictable adverse side effects of intensified price competition whose rectification, though perhaps somewhat deferrable, should be considered an essential and integral part of a responsible procompetitive policy.

It is important to disentangle the initiatives discussed above from the agenda items identified here. Because there is no longer any idea of imposing pervasive new controls on the industry, it should be possible to present the tax change and the new emphasis on choice in public programs as a clear signal to the private sector that the cost problem is now entirely in its lap and that nothing remaining in the federal policy pipeline will interfere with private cost-containment initiatives that might be taken. If such a signal were given, needed private innovations would not be held in abeyance pending completion of federal action on the complex issues remaining for attention. In view of the overriding need to relieve uncertainty in the private sector, the federal government should disavow the idea of a comprehensive legislative proposal and make clear that it will address particular problems one by one, always with a view to improving rather than interfering with the basic operation of the marketplace. Only if this can be done convincingly will private actors have a basis for confidence that their investments in innovation will pay off and will not shortly be devalued or rendered obsolete by some new federally sponsored surprise.

1. Mandating protection against the costs of catastrophic disease. Regulatory attention to the adequacy of citizens' catastrophic coverage is warranted because persons whose coverage proves inadequate are frequently treated without charge at the expense of the health care system as a whole and ultimately of the general public. In light of this fact, a strong case for regulatory intervention can be made under standard economic analysis. The problem is simply that consumers will act as "free riders," underinsuring themselves and taking advantage of the system's humanitarian impulses.

Although the need for public intervention to assure catastrophic protection is clear, the nature of the appropriate regulatory requirement is not. There appears to be great risk that, in compelling catastrophic coverage, government will act to insulate the affected consumer from all costs. The approach of mandating an ironclad guarantee of free care once some threshold is crossed carries with it a powerful threat of cost escalation and would invite continued regulation of system capacity, treatment methods, and appropriateness. Congress has so far been oblivious to the immense problems that pending proposals for catastrophic coverage could present despite their political appeal. Congress should not forget that, in dealing with this issue, it is addressing only a "free-rider" problem and should not lapse instead into a paternalistic mode of thinking that might cause it inadvertently to foreclose any catastrophic disease insurance that does not go as far as possible in removing financial and health risks.

2. Subsidizing private innovation and cost containment. Because of the riskiness of innovation and the difficulty of capturing gains from successful undertakings, change in private financing arrangements might be slower than is desirable or optimal. Government support for innovation would therefore seem desirable. The experience of the HMO Act suggests both the promise and the pitfalls of government subsidization of innovation in the organization of health services. Nevertheless, it should be possible through demonstrations and otherwise to provide temporary support for innovative strategies. Perhaps the HMO Act could itself be adapted to this purpose by expanding the types of innovation that it would encourage.

3. Replacing lost subsidies for education and research. Competition that increasingly focuses on price considerations will seriously jeopardize those institutional providers that have heretofore relied on excess revenues from patient care to support the training of medical personnel and the generation and dissemination of new knowledge. Although protecting the welfare of these institutions is not a sufficient reason for restraining competition, the threat posed to their valuable educational and research activities must be recognized as a major policy problem. Solutions to this problem will not be easy, since it will require new direct appropriations to replace, where necessary and appropriate, the implicit and uncontrolled subsidies that have been supporting the research and education enterprise.

4. Filling widening gaps in the "safety net." Competition will also erode the health care system's ability to generate the resources needed to provide care for the underinsured. This loss of hidden cross-subsidies will in turn impose on government the obligation to repair the holes that develop in society's "safety net" — that being the Reagan administration's term for the basic protection against financial hardship that it has promised to maintain for all citizens. Preservation of the safety net in a competitive world will require more than simply maintaining existing programs. New money will have to be provided to support those institutions

that have heretofore assumed a responsibility for providing uncompensated services to those who cannot pay. In an increasingly competitive world, those providers will be less and less able to pass on their unreimbursed costs and bad debts to increasingly cost-conscious payers and patients. Thus, government must accept some responsibility for shoring up the system's ability to continue providing essential services.

The goal of the competition strategy is to foster efficiency, and it is no part of its purpose to allow self-supporting patients to escape the necessity for contributing to the care of the poor through the system of internal subsidies that the health care system has maintained. Nevertheless, competition will necessarily erode opportunities for cross-subsidization and thus increase the necessity for public subsidies. Unfortunately, despite the overwhelming force of the argument for expanding direct subsidies to offset this unintended side effect, one cannot be sanguine about political leaders' willingness or ability to make the case for renewing and regularizing society's commitment to the poor. If there is a flaw in the competition strategy, it lies in these uncertainties. If government cannot address this social issue forthrightly and assure a decent minimum standard for all, then the competitive strategy could become, perhaps inadvertently, a vehicle for exacerbating social injustice. Although reliance on competition to allocate health resources does not necessarily imply a neglect of health care for the needy, society must be careful, in the present circumstances, not to default on its obligations.

5. Deregulating the industry. The success of the procompetition policy depends heavily on convincing independent actors -- employers and employees, insurers and other health plans, and individual providers -- that they, and not government, are responsible for controlling their own costs and that successful innovation in cost containment and improved efficiency will be rewarded. A tax change would send the appropriate message with respect to privately financed care, and moves to establish cost-conscious choice in public programs would reinforce the message. Sending a clear signal to the private sector also requires, however, the establishment of a convincing formula for deregulation.

Although not all forms of health sector regulation are equally destructive of competition and needed innovation, the presence of nearly wall-to-wall regulation in the industry creates, in addition to the absolute barriers, a climate and a psychology that reduce the likelihood that private actors will take the needed initiatives. Thus, without substantial deregulation, the private sector will probably make only the most obvious incremental moves in response to the changes in purchasers' incentives resulting from a change in the tax subsidy. Thus, one should expect little more than increased cost sharing, a continuation of gradual HMO development, and cutbacks in such benefits as dental and vision care. Far-reaching changes, affecting such fundamental matters as the symbolism surrounding employee health benefits and relationships between insurers and providers, would probably occur very slowly.

Unfortunately, regulation is quite pervasive in the health services industry and cannot be readily dismantled. For this reason, federal policy must specifically address regulation if the goal of establishing effective competition is to be achieved. Among all the forms of regulation, certificate-of-need laws are the most threatening to competition. They have frequently been employed to protect existing competitors against new market entrants and to allocate markets.

There are several ways in which deregulation might be pursued. Outright repeal of the federal health planning legislation would not achieve deregulation, however, since state certificate-of-need laws, enacted pursuant to the federal law, would remain in place. Although the federal government may now repent its compulsion of the states to adopt such laws, the federal responsibility for the pervasiveness of regulation cannot be avoided just by repealing its former mandate to the states. A great deal of other state regulation would also be unaffected by the repeal of federal regulatory legislation.

Repeal of the PSRO legislation in the name of deregulation would also fail to advance that purpose. Strictly speaking, PSROs are not engaged in regulation at all but are part of the administrative apparatus of the Medicare and Medicaid programs, being charged, in effect, with defining those programs' coverage. Unless PSROs' function of limiting government's payment responsibilities is otherwise performed, their elimination would amount to an expansion of Medicare and Medicaid benefits. Other federal controls designed to contain the costs of Medicare and Medicaid should also be distinguished from regulation, which governs the private sector. The redesign of Medicare and Medicaid, though badly needed as part of the procompetition strategy, would not, strictly speaking, be deregulation of the kind considered here.

The easiest way to deregulate the health care industry would be for the federal government preemptively to invalidate state laws that impair competitive developments. The Gephardt-Stockman bill would explicitly preempt state laws governing the regulation of provider prices, health plan characteristics and premiums, and the availability of services and facilities. An important tenet of current conservative political philosophy, however, is the restoration of state sovereignty, and sweeping preemption of state regulation of the health care industry would seem to violate this principle. In the current political environment, the most that is likely to be tolerated in the way of preemption is some selective federal dictation in aid of specific federal policies. Particular state-imposed restraints on competition and innovation that could be invalidated by federal law without doing violence to principles of federalism include the following: prohibitions on the provision of professional services by corporations; inhibitions on independent insurers' ability to practice selectivity in deciding which providers are eligible to provide covered services; restrictions on price cutting that might begin to appear in hospital rate-setting programs; unduly restrictive reserve and other requirements imposed on alternative delivery systems; and discriminatory premium taxes.

It is hard to be optimistic about the prospects for voluntary state action to foster competition. Indeed, the states' increasing Medicaid burdens will incline some of them more than ever toward regulation. State-sponsored protectionism to preserve cross-subsidies could readily defeat the federal initiative on behalf of competition. Moreover, provider and insurer influences are strong at the state level, and, even if definitive procompetitive action were taken, political forces would seek to undo it at the earliest opportunity or to subvert it by seemingly innocuous changes at crucial points. The regulatory uncertainty in local political environments could make meaningless any signal that the federal government sought to send to the private sector.

Continued federal oversight of state certificate-of-need programs and local health planning seems the most promising path to ultimate deregulation. The federal legislation was amended in 1979 to make the regulators and planners responsible for strengthening competition and allowing it to function where it is a constructive force. That law, if properly implemented (in accordance with specifications contained in my forthcoming book), amounts to a mandate gradually to deregulate the industry by recognizing, responding to, and encouraging reform in the financing system so that the demand side can appropriately discipline the supply side. The 1979 amendments thus provide a formula for deregulation in the critically important areas of market entry and investment. While it may take more than an Act of Congress to change the behavior of the planners and regulators, most of whom are true believers in regulation, political conditions now seem promising for winning their minds, if not their hearts.

Even though Congress should leave in place the requirement that existing state certificate-of-need programs must conform to procompetitive federal standards, the federal legislation should be amended to permit states to repeal their programs. With this change, the federal law would serve only to control overregulation by the states and not to confirm that entry controls are necessary. Several technical and clarifying amendments to the federal law and regulations are suggested in my book and would also help to send the needed signals and to prevent misunderstanding and evasion.

STATEMENT OF PAUL M. ELLWOOD, JR., M.D., PRESIDENT, INTERSTUDY

Dr. ELLWOOD. Mr. Chairman, I have spent a major portion of the last 12 years devising and analyzing the competitive approach to health care reform in the United States. There are obviously many aspects of competition that it is tempting to direct this testimony toward. But I believe that the most urgent problem is medicare. What happens with the medicare program really does shape the rest of the health system, as you have already stated.

It is my fear that if we don't enact an option for people on medicare to join competitive medical plans during this session of Congress, we are going to lose the opportunity to use competition as a means of cost containment, and Congress is going to find itself forced to enact some sort of price controls on the health industry in order to balance the budget by 1984.

Medicare program reform can be achieved in two stages; the first of which would be relatively simple politically and should be considered immediately while the second stage, which could be considered next session, would be politically more difficult. By engaging in this two-stage process, I believe that Congress can save at least a year of crucial time. Under the first stage, people in medicare would be given the option to join a health plan on a prepaid basis. Just introducing this option sets in motion the necessary administrative machinery and allows medicare recipients to get used to the idea of having this choice. By the time Congress confronts the second stage, which would be mandatory and would tie the per capita reimbursement rate to general inflation indices, rather than to current medical care costs, a great deal of the time and energy which would ordinarily be necessary for implementing this process would have been saved.

The problems of medicare have been termed a crisis for at least the last 12 years. Certainly they are a crisis for the Government right now, but they are not a problem for the Government, alone.

People who are on medicare are experiencing tremendous difficulties in dealing with the complexities of this program. It is very costly to them. I do not think we should be considering the introduction of cost sharing in medicare here. Fifty percent of all medicare recipients have already found it desirable, if not necessary, to insure themselves in some way beyond the insurance that the Government is providing.

No one can accuse this committee or the House of Representatives of having ignored medicare reform. This committee first considered the idea of the voucher system for medicare in 1970 and actually incorporated this idea as an amendment to titles XVIII and XIX of the Social Security Act. In fact, that amendment very much resembles those which are under consideration today. In May 1970, the entire House of Representatives went on to pass this optional voucher program as part of the medicare amendments.

Some might argue, as they did in 1970, that time has run out on this approach to medicare reform. The standard argument has not been against the idea of prepayment in medicare as much as it has been related to the notion that relying on incentives and giving people choices is going to take too long to be effective. However, although I believe we have already wasted 12 years, I suspect the same kind of arguments will still be raised.

The present situation is really very different from the one this committee faced 12 years ago. There were very few options available to people in this country at that time.

If HMO's are used as an example, there were only 40 HMO's operating then. There were only about 3 million people in them. Now there are more than 240 competitive medical plans, or HMO's, in the United States. They are operating in 170 different communities. There are now 10 million people that belong to them.

There are a number of communities in which competition has become intense indeed, but it is not competition that has been stimulated by the Government. Competition in these communities has been if anything, inhibited by Government programs but stimulated by employers and insurers offering people choices.

Furthermore, during the last couple of years we have had some experience with allowing people on medicare to joint competitive medical plans. There are four such experiments operating in the United States involving about 30,000 medicare recipients who have opted to join competitive medical plans.

This is turning out to be a very popular idea. For instance, it has been available to people on medicare in the Twin Cities for 5 months and during that 5-month period, 8 percent of those who were eligible for this program have joined it.

We have never observed people embracing this kind of choice at such a fast rate. It is a major decision for people on medicare to make. It may mean changing doctors. It certainly means joining a health care arrangement that is at best experimental.

I think the fact that people on medicare have joined in such numbers is indicative of how appealing this idea is to them. For one thing, they find it is much more simple for them. They have also discovered that medical care is guaranteed to be available to them. In every one of the experiments, the HMO's have found that they can offer more benefits with the Government's capitation payments than are currently available under medicare.

The best example of this is probably Kaiser Portland. It is paid at a rate which is 5-percent less than the Government is spending in Portland on medicare reimbursements. But, with this amount plus an additional premium payment of $17 a month, Kaiser is not only able to provide all the benefits that medicare provides, but it is also able to eliminate all the deductibles on doctor visits and all costs on hospitalization, and provide free dental care, including fillings and prostheses. It is also providing free eyeglasses and hearing aids, and preventive health services. No wonder it is a very attractive idea.

Furthermore, a program which allows medicare recipients to join competitive medical plans on a prepaid basis has tremendous leverage on the rest of the health system. One person on medicare joining a competitive medical plans is equivalent to five employees joining such a plan. Each person on medicare consumes about five times as much hospitalization as a typical employee. Medicare spends around $150 a month on each of its beneficiaries, whereas in the employee population the expenditures are only about $30 a month. Thus, you can imagine how attractive the idea is of introducing this kind of choice and giving people on medicare the option to leave their existing sources of care and choose one that is less costly.

As I have previously suggested, this can be done in two stages. In the first stage, people on medicare would be given the option of joining health plans which would be paid on the basis of a per capita arrangement that is dependent upon the amount that medicare spends in the community right now. Every single proposal to reform medicare which has been introduced begins with this notion of arriving at a capitation rate that is based on a community's historical medical care expenditures.

The hardest step, and the one that I suggest Congress consider as a second stage, is the question of how this rate should be adjusted in ensuing years. I suspect that Congress will find that the rate should be based on something other than a community's current medical care costs.

The second element of any first stage is simply identifying the kinds of organizations Congress will allow to accept these per capita payments. This can range from insurance companies to HMO's.

The third thing I think is important to have in this first stage is a provision that medicare be allowed to retain any savings. I do not think it should be a question of people on medicare receiving rebates. Medicare coverage is too inadequate at this time. The main advantage of this program for medicare recipients is that they will receive expanded benefits and it is not going to cost them as much out-of-pocket as it does now. When a person is over 65 and faces a virtually certain specter of hospitalization every year or two, he or she will work hard to avoid inadequate coverage.

Following the first stage which I have just described, Congress may want to consider the more difficult problems of making the program mandatory rather than optional, and devising ways of arriving at capitation rates that are different from the current medical care costs in an area.

To conclude, I think we can accomplish most of what needs to be accomplished with this two-stage program, rather than trying to jump into the whole thing at once, or waiting for the administration's proposals, which are much more global and which I suspect will lead to a year or more of debate before going anywhere. By that time I think it is going to be too late.

[The prepared statement follows:]

STATEMENT OF PAUL M. ELLWOOD, JR., M.D., PRESIDENT, INTERSTUDY

I am Dr. Paul Ellwood, President of InterStudy, a nonprofit health delivery and policy group located in Minneapolis, Minnesota. I have spent a major portion of the last 12 years devising and analyzing the competitive approach to health care reform in the United States. There are obviously many implications of the introduction of competition to the health industry towards which I could direct today's testimony; however, I believe that the most urgent of these relates to the future of the Medicare program. It is my fear that if legislation giving people on Medicare the option to join competitive medical plans is not addressed this session, we undoubtedly will face the specter of price controls applied throughout the health system in order to achieve a balanced budget in 1984. By considering Medicare reform in two stages, one state now and one next session, Congress could enact some simple changes that would accelerate the rate of comprehensive Medicare program reform by perhaps one year.

CRISIS IN THE MEDICARE PROGRAM

The problems of Medicare have been referred to as reaching crisis proportions in each of the 12 years since the idea of capitating the program was first proposed. But the crisis has deepened as the government seeks to get its own expenditures under control. A Medicare program, whose rates of cost escalation far exceed those of general inflation, is no longer acceptable. To add to this present sense of urgency, the Board of Trustees of the Federal Hospital Insurance Trust Fund has recently made the prediction that the Fund will be depleted within the next decade. The widely discussed proposal of borrowing monies from this Fund and the Supplemental Insurance Trust Fund to stave off bankruptcy of the Social Security Program will only further accelerate the impending financial problems of the Medicare program.

The problems of the Medicare program are not simply those of the federal government. It has been widely observed that individuals on Medicare are confused by the complexity of the program. They also must face growing personal expenditures for medical care as medical price inflation drives up the amount that they must pay out-of-pocket or through other means. In fact, more than 50 percent of all Medicare recipients have attempted to protect themselves against such Medicare program uncertainties by purchasing supplemental health insurance.

No one can accuse the Ways and Means Committee of having overlooked or failed to act on the competitive approach to Medicare reform. In 1970, this committee not only considered but accepted the idea in very much the same form that is proposed today, as an amendment to Titles XVII and XIX of the Social Security Act. The bill including this concept (H.R. 17550) was passed by the whole House of Representatives on May 21, 1970. During the current legislative session, a per capita approach to Medicare reimbursement (H.R. 3399) was adopted by the House Energy and Commerce Committee.

Some might argue today, as others did back in 1970, that time has run out for the implementation of such a program. These opponents will suggest, just as they did 11 years ago, that the overriding problems of health care cost inflation are now so serious that installing an optional voucher program under Medicare would take too long and would be too difficult to administer.

The present situation is, however, very different from that of 1970, and although the Medicare program has not offered people the option of joining HMOs, much of private industry has done so. In fact, in 1970 there were fewer than 40 HMOs in existence in this country that served only about 3 million people. Today there are more than 240 such plans in operation in approximately 170 communities serving more than 10 million individuals. Furthermore, intense competition has developed among prepaid plans that should allow a variety of choices for people on Medicare in such diverse part of the country as Minneapolis-St. Paul, Denver, Boston, Seattle, Portland, Phoenix, Dallas, as well as the entire State of California.

Currently, the Health Care Financing Administration (HCFA) is conducting Medicare demonstrations based on the capitation idea. Thirty thousand Seniors are participating in these experiments which have provided considerable data and an understanding of the application of a per capita reimbursement method to the Medicare program. InterStudy's involvement in a Twin Cities Medicare demonstration which permits individuals on Medicare to have the option of joining any one of four HMOs has given us a first-hand view of the benefits and problems involved in making these kinds of changes in the Medicare program.

THE SOLUTION: PHASING IN A PER CAPITA REIMBURSEMENT SYSTEM UNDER MEDICARE

I suggest that the most feasible approach to achieving the necessary changes in the Medicare program involves two phases. In the first phase (Phase I), an optional Medicare voucher system would be introduced. This phase would likely confront relatively minor political and legislative opposition, but would be administratively difficult and time consuming. Although Phase I would have the advantage of widespread acceptance because of its optional nature, it could be followed by a second phase (Phase II) which would involve the conversion of the Medicare program to a budgeted system. This phase would likely face more political and legislative opposition while administrative problems would be minimal provided Phase I had already been enacted.

PHASE I: AN OPTIONAL VOUCHER PROGRAM UNDER MEDICARE

Phase I Medicare program revisions should include the following important elements:

1. An optional per capita system of reimbursement which would be based, at least initially, on the historic Medicare costs in a geographic area adjusted for age, sex, and health status. All Medicare voucher programs that have been proposed start out with this method of establishing a capitation rate.
2. The identification of the types of organizations from which the Administration could select those which would be paid on a capitation basis for members who were on Medicare. This could most easily be done by including state and federally qualified HMOs at the outset.
3. The requirement that participating providers offer benefits which would be equal to, if not better than, current Medicare benefits, and that these providers be encouraged to apply savings to increase the benefits offered.

InterStudy has recently completed a survey of Seniors who expressed interest in the Twin Cities' Medicare Demonstration Project. The major reasons cited by the respondents for not joining include a reluctance to change physicians, confusion abut the demonstration, and its experimental nature.

Despite the many advantages inherent in immediate passage of a Phase I program, it is important to point out some of its problems as well. The administrative difficulty expected in Phase I has already been alluded to. For example, people do not join health plans at random. They usually join such plans for a reason, be it that their physician is a member, the benefits offered are more extensive, or that they have an illness requiring treatment. When capitation rates are based solely on age, sex, and place of residence, there is always a risk that the federal government or participating providers will suffer from adverse selection. That is, some plans will attract members with above-average health while others will attract a much less healthy population. Thus, in order to assure that reimbursement matches risk, the Medicare per capita reimbursement rate should be adjusted for health status. I am, however, well aware that uncertainty still exists as to what is the best method for calculating health status. My contention is that the one year or more we would gain through serious study and application of these and other administrative problems would be very advantageous.

PHASE II: A BUDGETED MEDICARE SYSTEM

While it is essential that Congress move quickly in establishing an optional voucher system under Medicare, in order to further reduce the threat of the Hospital Trust Fund's depletion this action must be followed by the conversion of the Medicare program to a budgeted system. Three important measures need to be included in this second phase in order to ensure the slowing of Medicare program costs:

1. The adjustment of Medicare capitation rates on the basis of some other measure than current medical care costs. I suggest that inflation adjustments for Medicare should be pegged at some general index of consumer prices, such as the GNP deflator, rather than adhering to a price index strictly for medical care. The medical care component of the CPI has had the tendency to rise faster than the overall economy and if used as the index would continue to drive up the price Medicare pays for services. In fact, indexing the per capita reimbursement to some general index is crucial to saving money in the new Medicare system and to saving Medicare itself.
2. Broadening of the types of organizations which could participate in the program to the widest extent possible to include insurance companies and various other types of plans. The objective should be one of encouraging innovation in participating programs.

3. The phasing in of a fully budgeted and prepaid reimbursement system under Medicare.

Chairman Jacobs. Thank you, Doctor.

Mr. Duncan?

Mr. Duncan. Thank you, Mr. Chairman.

Doctor, in view of the fact that most States have antitrust policies, would it be necessary that the Federal antitrust laws also be enforced in order to accomplish the competitive system?

Mr. Havighurst. Mr. Duncan, I think very definitely that the Federal antitrust laws must be enforced. State antitrust enforcement is very uneven. In many places it is almost nonexistent. These restraints by the medical profession and other professions have existed for generations without correction by the States. It is only recently that the Federal antitrust laws have been readily applicable to those restraints because of questions about interstate commerce and because of the idea that the Federal antitrust laws might not apply to the learned professions at all.

It seems to me completely obvious that the States are not the place to look for antitrust enforcement in this industry. The States have, I think, systematically defaulted both in antitrust enforcement and in their legislative efforts to deal with professional matters. They have tended to do what the professions want them to do, and their infringements on competition are very extensive and quite serious, and consumers have paid dearly for the anticompetitive actions the States have taken.

I think the Federal Government is now developing some expertise in the antitrust problems of this industry and is making a real and important difference to consumers by finally taking professional groups out of control of the economic environment in which they operate.

Antitrust enforcement is an absolutely essential feature of a procompetitive policy. I think it would be frustrated if we only looked to States to deal with this problem.

Mr. Duncan. Dr. Ellwood, some people feel in a system where plans compete with one another on the basis of price and benefits provided, there will be individuals who would switch from less comprehensive plans to another, or more comprehensively extensive health plans when they anticipate they or their families will need more services.

Are you aware of any realistic suggestions for dealing with that problem?

Dr. Ellwood. There is no doubt that switching occurs between these plans, but I think that is a reasonable thing for people to do—to pick out a source of medical care at a price that they find is desirable.

Mr. Duncan. Rather than requiring adverse selection?

Dr. Ellwood. In medicare, adverse selection is a very real problem. There is no such thing as a health plan that attracts an average consumer. If, for example, a doctor in a plan happens to be a cancer specialist, then that plan is going to attract a lot of people with cancer. Thus, I feel that in medicare, we are going to have to be able to adjust the price that the Government is willing to pay based on the health status of the individual. Up until this time, we have arrived at this rate based on the medical care prices in the community as well as on the age and sex of the individual.

Adjusting the rate of capitation payments made to a plan on the basis of the health status of its members will insure that a plan which attracts a lot of unhealthy people will be paid more. If, however, the plan attracts a lot of healthy people, by, for example, advertising only in "Runners World", it ought to be paid less.

Mr. DUNCAN. Thank you. I thank both of you.

Chairman JACOBS. Mr. Gephardt?

Mr. GEPHARDT. Thank you, Mr. Chairman.

I appreciate your testimony very much. I would like to ask both of you if you feel that Dr. Ellwood's suggestion of doing the medicare option and putting off the rest of the agenda for the tax change and medicaid, would be the way to go.

Obviously, Dr. Ellwood, you feel that way. Do you feel that is all we need to do, that that in itself would be enough, or do you think we should do more later?

Mr. HAVIGHURST. I think that the two steps that I think are essential—the tax change and some choice in public programs, particularly medicare—could be proceeded with independently. I think it would actually be a mistake to make all of this part of one big package.

We have been having big reform packages offered for years in this industry. The effect of each big proposal has been to cause everybody to stand around waiting for something finally to happen. I think the more we can do sooner, even on a piecemeal basis, the better off we would be.

So, I would very much like to see the medicare option go ahead as soon as possible.

Dr. ELLWOOD. My feeling is that of all the things Congress can do—the tax cap, multiple choice, and so forth—doing something with medicare is the most important. After all, the Government is the big buyer of health care here, and that is the biggest chip with which it can play.

Also, medicare options are more predictable, more decisive, and the one major thing on the agenda that we have left out.

I suspect that on the matter of a tax cap, some things are happening in employee benefit design that may achieve what the committee would hope to achieve with a tax cap without going that far.

The big change in employee benefit design is offering flexible benefits, sort of a menu of choices to employees, for example, the employer says:

> We are prepared to spend $100 a month on benefits, but we are going to give you a series of choices. You can put some of it into pensions or some of it into vacation or some of it into health care.

The effect of this is to put people in the position where they can see that if they spend too much on their medical care coverage, they lose out on other things.

I think that this one change in employee benefit design may well achieve a lot of the things Congress would hope to achieve by capping the tax. I am not saying that the tax cap is not desirable, but I think much of this is going to happen anyway. However, the

Federal Government alone controls the medicare program and its problems.

Mr. GEPHARDT. May I ask you a question in that regard in the Minneapolis experience? You say the experiment has done well. You got 8 percent of the people in. It seems to be succeeding because the people appear to be so far at least happy.

Do you think you have a lot of adverse selection going on there? Are you getting the well medicare people into your plan, or do you think it is mixed?

Dr. ELLWOOD. The design of the Minneapolis experiment allows providers to screen the people who join the plans 11 out of 12 months a year. I would never recommend that Congress do that in a permanent program. Under such circumstances, of course, the providers are having satisfactory experiences. They can insure that they do. But in the long run there are going to be peculiar selections.

The health industry itself is already segmented. Each obstetrician wants pregnant women as his patients. So the idea that just by giving people a choice they will somehow randomly distribute themselves across a system is absurd.

Obviously there are going to be some plans that attract more sick people, and some plans that attract more well people. There will also be an effort made by plans to attract more well people. Under those circumstances, I think we have to reward the plans that attract sick people and take away from those that attract well ones.

I do not know whether I am being absolutely clear on this point, but every HMO I have had occasion to look at, has something unusual about its selection based on where it is located, who works for it, and the bedside manner of the people who operate it. Adjustment must be made for such differences.

Mr. GEPHARDT. Dr. Ellwood, in the Twin Cities there are several competing HMO's, as we are all aware. I would like to know what is the reaction there of the average worker, the union member? Do they actually receive less care?

Further, I would like to ask if there was a tax rebate offered to them, what impact do you anticipate that would have on their receptivity to HMO's?

Dr. ELLWOOD. Our experience has been so positive that it is hard to say that a tax credit could make that much difference. Already 50 percent of the people who have had a chance to join a plan have joined. Eighty-two percent of Prudential's employees, for instance, have left Prudential coverage to join an HMO.

I think that of all the things which could be done to promote competition, equalizing the contribution rate would be the most powerful one. In other words insisting that an employer, who is willing to contribute X number of dollars for HMO coverage, contribute no more than that amount for other health insurance coverage, or vice versa.

Our employers have failed to take advantage of this concept. What has happened in Minneapolis is that HMO premiums are now lower than that of conventional health insurance, and employers have gone on paying the higher premium for conventional coverage. Therefore, whatever impact competition might have on the rest of the system has been diluted.

I think we do need to make it easy for employers to equalize the contribution rate. I suspect that this might be more powerful than a tax rebate. I also feel that keeping employers in the picture is rather desirable. What we are going to be faced with here are a lot of large organizations delivering medical care, and a lot of large employers who have to contend with enormous health expenditures for their employees.

The phenomenon of large buyers (employers) confronting large sellers I think is an important, desirable feature to retain in the system. Employers in our community are becoming very, very sophisticated about medical care.

Mr. GEPHARDT. Thank you, Mr. Chairman.

Chairman JACOBS. Professor Havighurst, have you an opinion as to how much and how soon medical prices would be brought down as a consequence of the income tax changes that you have discussed?

Mr. HAVIGHURST. No, Mr. Chairman, I don't. I think it is somewhat important to emphasize, as I tried to do earlier in different terms, that the real object here is not cost containment as such.

I think we need to recognize that the American people are entitled to have in the way of health care whatever it is they want to buy with their own money, and that the object of the tax change proposal is to make sure they are spending their own money and not being excessively subsidized in their spending decisions by Government through the tax system. Once they are put in a position where they can exercise choice and are offered a full range of choice in a market that is not restrained as it has been in the past by antitrust violations, then people's decisions about what to purchase ought to be respected.

Now, I would guess that they will in fact choose to economize in substantial numbers and that in fact providers will be put under competitive pressure to lower their fees and charges, that the controls on utilization will be more effective than anything we have seen, and that costs will come down.

But it may be that consumers like the kinds of coverage they have today, and if that is the kind they choose to continue, I would not quarrel with that. I would say that we do not have a health care cost problem as long as people are spending their own money and the market is competitive.

So, I would like to state the issue differently. I think the problem is to create a process in which we can have confidence so that the level of spending we eventually arrive at is one that reflects consumer preferences and sensible public subsidies. We have never had that in this country, and it seems easy enough to establish. Once you state the problem that way, I think the policy decisions and choices are somewhat easier. Government then has less responsibility to intervene at various points. Its sole job is to make sure that that process works and that the correct incentives are in place.

Chairman JACOBS. Perhaps I would then move from opinion to a guess. Do you have a guess as to what the final result might be in terms of medical prices, in terms of a reduction?

Mr. **Havighurst**. I think costs would decline. I do have the concern, which I did try to express briefly in my statement, that some of the savings that consumers would enjoy in a competitive health system, are not real savings. Some of those savings would reflect consumer's success in avoiding contributing to some of the system's expenses that don't involve the care that they actually receive. In other words, consumers will avoid hospitals that charge more because they are involved in education or research, or because they are taking care of a lot of patients who cannot pay, and then are billing those costs to the people who can pay. In a competitive world, where everybody is more cost conscious, there will be some cream skimming, and people will start avoiding high-cost providers. Some of the savings they derive won't be real savings since the costs may have to be picked up in another form, probably by Government.

So we would kid ourselves if we thought all those savings were in fact from increased efficiency. There would be, nevertheless, some real savings from efficiency. I would think they would be substantial, but I would never try to estimate them. I am, after all, a lawyer.

Chairman **Jacobs**. Really, the answer to my two questions then is no. You do not have an opinion or a guess as to how much it might be. I say for your edification and repetition in the record that Dr. Rivlin predicts 1 to 2 percent general medical price reductions by 1988.

With that, we thank the panel for its contribution.

The next panel is the American Federation of Labor and Congress of Industrial Organizations, Mr. Bert Seidman, director of the Department of Social Security, and Mr. J. R. McGlotten, associate director, Department of Legislation. Included in the panel also is Melvin Glasser, director of the Committee for National Health Insurance, and Ms. Cathy Schoen, special assistant to the president, Service Employees International Union.

You may proceed.

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR & CONGRESS OF INDUSTRIAL ORGANIZATIONS, ACCOMPANIED BY ROBERT McGLOTTEN, ASSOCIATE DIRECTOR, DEPARTMENT OF LEGISLATION

Mr. **Seidman**. Thank you, Mr. Chairman.

Let me first say that pursuant to your wishes, I will try to confine my oral remarks to a minimum. But I respectfully request that my full detailed statement be included in the record, and I would go further than that. I am saying this not just in a pro forma sense, but there is much in that statement which I will not have time to state orally.

Chairman **Jacobs**. Yes; Mr. Seidman. It will be included in the record. To the extent we are capable of bringing it about, it will be included on the front page of the Washington Post tomorrow morning.

Mr. **Seidman**. I appreciate that. That would be a real accomplishment.

Mr. Chairman, the AFL-CIO welcomes this opportunity to express its views with respect to the so-called competition proposals now before Congress, and an anticipated bill expected from the administration.

If Congress were to enact such bills, health care costs would increase, not decrease, and more, not less regulation would be required.

The AFL-CIO has analyzed the three bills which I understand the committee is considering—H.R. 850, S. 433 and S. 139.

The three bills, in our opinion, are based upon the same faulty assumptions and because they are, we are not disposed to quibble over their detailed provisions.

The competition theories refuse to recognize that the demand for health services is dominated by physicians and not patients. Physicians control 70 to 75 percent of all health care expenditures.

There is no magic solution to cost containment in health care. Fee schedules in lieu of open-ended reimbursement could cut costs, as could cost containment incentives, such as capitation payments for physician services.

An end to cost plus reimbursement for hospitals would be a large step forward, but Congress failed to enact hospital cost containment legislation last year.

Negotiating hospital charges is another approach that appears to work very well in Canada. There is competition now in the medical marketplace. The development of prepaid group practice plans has given the fee for services system a real run for its money in those areas in which prepaid group practice plans are well-established.

Unfortunately, the provisions of the various competitive proposals would strip PPGP's of most of their financial advantages and their appeal to consumers.

The provisions in the proposals requiring a ceiling on employer contributions, the required offering of a low option plan with attendant adverse selection against comprehensive plans with higher premium costs, and the lack of financing for preventive care would likely eliminate existing prepaid group practice plans from the marketplace, as well as the hope that new ones will be developed.

Thus, we can see no outlook for these competition proposals except less competition. The competition theory wrongly assumes that the consumer has the necessary knowledge of medicine of actuarial mathematics to make a rational decision as to which provider or insurer offers the best buy.

Aside from the fact that consumers cannot predict the nature and severity of some future disease or accident, the illness can only be treated by following the regimen that the doctor lays out, whether it be hospitalization or out-patient treatment.

A close doctor-patient relationship, priced by patients and doctors alike, precludes shopping around for the least expensive doctor.

It is equally impossible for consumers to determine the best by among a puzzling array of available health insurance policies, each with several pages of fine print outlining deductible and coinsurance provisions, limitations, exclusions, and so on.

The best buy for consumers is a comprehensive plan that gives them assurance that regardless of the nature of any future disease, their policy or plan will pay all or the great proportion of its cost.

The proof of this, Mr. Chairman, is that most consumers, if they have the opportunity to do so, will choose a comprehensive plan, if they can afford it.

It is hard for persons who are relatively affluent to understand that deductibles and coinsurance are a barrier to necessary care. Studies have shown that deductibles deter or delay care for the poor, resulting in an increase in costly hospitalization and a net increase in total medical care costs.

Coinsurance does not save money but simply transfers costs from prepaid insurance to out-of-pocket expense at the time service is rendered, thus causing financial hardship for most families when they become ill.

Catastrophic insurance is very inexpensive. That is in dollars, not in what it results in for people, because it helps so few people. To place emphasis on reimbursement for catastrophic illness, however, is clearly costly in the long run.

H.R. 850 proposes to allow medicare beneficiaries a choice of public or private insurance. It is alleged this will reduce medical care costs for the disabled and the elderly. The cost of administration of the medicare program is only 3.1 percent of benefit payments, despite the fact that a large number of insurance costs are involved.

The cost of private insurance exceeds 12 percent. It would be impossible, therefore, for private insurance to match the overhead costs of the public program. Nor would there be less regulation under H.R. 850.

Mr. Chairman, the words "as determined by the Secretary" or equivalent phrases occur over 60 times in that bill.

All of the competition bills would levy a regressive tax on all employees having comprehensive health insurance coverage. For example, for an average family of four, one-half of the recently enacted tax cuts would be taken away.

Many poor families with below average incomes or large families could lose their entire tax cut. You will find a table attached to my full statement which sets that out in more detail.

Mr. Chairman, unions have called over the years for comprehensive health insurance programs. This is what union members and all consumers want. The AFL-CIO is determined to preserve the gains that have been made through collective bargaining.

We urge the Congress not to vote to increase taxes on the working population or to vote to disinsure millions of Americans from the health protection that they now enjoy.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF BERT SEIDMAN, DIRECTOR, DEPARTMENT OF SOCIAL SECURITY, AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS

Mr. Chairman and members of the Health Subcommittee, the AFL-CIO welcomes this opportunity to express its views with respect to H. R. 850, S. 433 and S. 139. We cannot accept the unfounded premise that competition in the health care industry can contain health care costs. On the contrary, if these bills did what is claimed for them; namely, deregulate the health industry and substitute the marketplace as a cost containment strategy, the result would be exactly the opposite of that intended by the sponsors. Enactment of the so-called "competition" proposal would impose a highly unrealistic, fanciful and harmful scheme on the American people.

We will not deal with these three bills separately nor attempt to indicate a preference for some provisions in one of the bills as opposed to other provisions in the other bills since the basic concepts of all three do not conform to the reality of the medical care marketplace. We will not, therefore, quibble about details.

The three proposals can be summarized as follows: All three bills would require employers to offer their employees a choice of more than one insurance or prepayment plan. They would require employers to contribute the same amount for each employee in the plan. The employer contribution would be subject to a ceiling. After the ceiling is exceeded, the employee would be subject to income tax for the excess contributions.

Employees who might desire a plan with comprehensive benefits and no copayments would have to pay extra out of gross or pretaxed income. Those who elected a plan with minimal benefits and with deductibles and copayments (or other limitations) costing less than the employer contribution would receive a tax-exempt refund for electing to be covered by the low-cost plan. In effect, this is a bribe for employees to disinsure themselves and try to pay out-of-pocket for health services they may require if they become sick.

These provisions would be enforced through the internal revenue code.

Central to the cost containment strategy of these bills is the notion that by establishing a ceiling on employer contributions for health insurance employees and other consumers of health services would be encouraged to shop around for the less expensive physicians, hospitals, insurers and Health Maintenance Organizations and that in turn, through the invisible hand of competition, providers and insurers, would be forced to reduce costs.

It is, therefore, assumed by the proponents of these bills that the delivery of health services can be adapted or transformed into the competitive economic model now exceedingly rare today where the national marketplace is dominated by major corporations and even the world market is dominated by multinational corporations. The fact that the medical care market is dominated by physicians is ignored. Any rational cost containment strategy must address itself to this issue. These bills do not.

For competition to work as a means of controlling medical care costs, the following assumptions would have to be valid:

1. Without regulation, the providers of medical care: physicians, hospitals, nursing homes, etc., would compete or could be induced to compete for patients on the basis of price alone.
2. Consumers of medical care or patients have a sufficient knowledge of the clinical practice of medicine, the quality of care provided by various doctors and hospitals and the probabilities of illness and even actuarial mathematics, to make an informed choice of insured or prepaid health plans offered at various prices.
3. The traditional doctor-patient relationship does not exist and, therefore, patients are free to shop around regardless of their doctors' wishes or opinions.
4. The young and healthy would not choose a low-cost plan leaving the old, sick and disabled to purchase insurance the cost of which would be too high for those who need it the most.
5. Deductibles reduce total health care cost.
6. Catastrophic insurance will not increase the long-run cost of health care.

7. Competition among providers and insurers can eliminate the need for regulation.

Merely stating the assumptions necessary to make such a fanciful plan work is prima facie evidence that it would not work. But let us take up these assumptions one at a time.

Competition

The first principle which governs the demand for medical care is that the demand is created by the supplier, that is, the physician and not the patient.

* It is the doctor who decides whether a patient goes to a hospital or receives much less expensive treatment on an outpatient basis.

* It is the doctor who decides when a patient can be transferred from a hospital to an extended care facility. It is the doctor who decides when the patient can be discharged from a hospital or nursing home.

* It is the doctor who decides how often the patient should come to the office for treatment and the number of hospital visits that need to be made by the doctor.

* It is the doctor who orders diagnostic laboratory tests.

* It is the doctor who prescribes drugs, either by brand name or less costly but equally effective generic equivalents.

* It is the patient's physician who leaves instructions with the house staff or the nurse.

Patients know this. When patients go to a physician with symptoms -- or perhaps for a physical examination -- they place themselves under the doctor's direction. That is why physicians control from 70-75 percent of all health care expenditures. In fact, no other profession or business controls both the price and the demand for its services.

Patients cannot check into a hospital like a hotel so they cannot choose among hospitals. They must be admitted by their doctor. Can anyone imagine sick patients challenging their doctor's decision that they need to be hospitalized or challenging their decision as to which hospital they should go?

It is unrealistic to even hypothesize that a patient would shop around for cheaper hospitals.

And who decides when a patient can be discharged? Doctor or patient? Can the patient just check out?

And can it be imagined that patients would challenge their doctor's decision as to what laboratory tests might be needed to establish an accurate diagnosis? Can you imagine a patient telling the doctor he or she doesn't want a CAT (computerized axial tomography) scan because it is too expensive? One patient in a hundred would even know what a CAT scan is. Can you imagine a patient asking the cost of a particular laboratory test?

Even the most enthusiastic supporters of the competition theory know it is the doctor who controls medical care costs so they have concocted an indirect way of pressuring physicians to control health care costs. In order to appeal to the presumed "cost conscious" consumer, third parties would compete for customers on the basis of lower premium costs. Insurers would, then, pressure physicians to control medical care costs who in turn would then be motivated to form Health Maintenance Organizations or other forms of organized health care delivery systems.

This Rube Goldberg contraption is supposed to in some way, somehow contain health care costs.

The causes of the cost escalation in medical care are hardly a mystery. One is the fee-for-service system of reimbursing physicians. This method of payment rewards physicians in proportion to the number of services and the expense of such services whether necessary or not. Physicians have somewhat less than a strong enthusiasm for utilization control even if they do it themselves as the very uneven record of the Professional Standards Review Organizations (PSROs) has demonstrated.

Negotiated fee schedules might conceivably put some kind of a lid on physician charges but organized medicine has bitterly resisted this approach.

There are no regulations or controls over what doctors charge for their private patients and only a payment system under

Medicare that, in effect, legalizes fees at a level doctors themselves decide, the so-called "customary and prevailing fee." Only under Medicaid are there some controls in some states, but this has tended to perpetuate a two-class system of medical care discriminating against the poor.

The fact is that most doctors are virtually unregulated now. The little competition that does exist takes a perverted form. Doctors migrate to the high income suburban areas charging higher fees and over-doctoring affluent patients leaving inner city and rural areas under-doctored.

Cost-plus reimbursement of hospitals is the other main reason why medical care is taking an increasing proportion of the gross national product (GNP). Because hospital costs have exploded to such high levels, efforts have been made at both national and state levels to constrain hospital costs.

Hospitals are, of course, heavily regulated. That is why some hospital organizations support these bills in the hope that these constraints will be removed. Over one-half of most hospitals' budgets come from public funds, principally Medicare and Medicaid. Could they expect with enactment of competition legislation they could continue to partake of huge public funds and also be relieved of all effective cost constraints?

What competition exists among hospitals undermines rather than encourages low cost operation. Doctors, not patients, are the hospital's customers because it is the doctor who admits patients. Hospitals vie to introduce new expensive technology to attract doctors without regard for cost or cost effectiveness. In fact, it is generally assumed that the new is better than the old without any evaluation of therapeutic value. Doctors prefer high technology hospitals with the best and latest equipment. Hospital administrators know this and virtually every hospital aspires to be a major medical center. In a market structure in which consumers do not make basic consumption decisions about hospital services and are forced to rely on the preferences and decisions of physicians, competition among institutions for physicians' favor has become inordinately expensive.

The idea that competition among health care providers can control costs contradicts the historical evidence. Competition among providers for patients has contributed to unnecessary surgery, proliferation of expensive and underused equipment and the construction of unneeded hospitals and an excess of hospital beds.

Competition among insurers has made it difficult for poor risks to get coverage. It has promoted skimming. Competition with experience-rated commercial insurance plans forced Blue Cross to abandon long ago community rating which spreads the cost of illness fairly over all subscribers.

Because the competition bills emphasize deductibles thereby discouraging health maintenance, early diagnosis and treatment but provide catastrophic benefits for acute illness, their financing provisions are not compatible with prepaid group practice plans. Progress in developing PPGPs would, therefore, be thwarted.

If the benefit package is precisely defined in legislation, as in Medicare, for example, and if insurers would compete for subscribers with the same age, sex and disability characteristics, the underlying cost of providing medical services under the fee-for-service system would be the same for all third party insurers.

The only area in which insurers could possibly compete would be on the basis of overhead or administrative costs superimposed on the fee-for-service system. These include the cost of the mechanical processing of claims, advertising and marketing expense and other overhead. For large employee groups, the overhead cost of administration is less than five percent. For small groups, it can be as high as 25 or 30 percent and the cost of marketing health insurance policies to individuals amounts to one-half of the premium or of the payments for benefits. These bills would virtually eliminate the low cost group purchase of insurance and substitute individual choice with its attendant high marketing and administrative costs.

To succeed in the insurance business in a competitive market, a health insurance company would likely place emphasis on:

* Dealing with employers who have employees in non-hazardous occupations, younger single males preferred.

* Including high deductibles and coinsurance provisions to assure low premiums and favorable self-selection by the healthy.

* Avoiding open enrollment periods. If required by law, establishing outlying offices for recruitment and servicing in

the suburbs, thereby making it difficult for residents of the inner city to enroll.

* Promoting experience rating and resisting community rating.

* Promoting a safety-net for the aged, the disabled and the poor financed or subsidized by government so that there would be no possibility that the insurance company would have to pay the full cost to cover these groups.

* Providing a catastrophic benefit for those who incur substantial out-of-pocket expense. It only costs pennies and sounds wonderful -- protection up to $100,000, $200,000 or a million dollars. It has great appeal to the rich who don't mind the first few thousand of medical expense. The rich are also healthier.

* Disclosing as little information as possible. This Administration is not likely to get on the company's back.

Impact on Prepaid Group Practice Plans

These bills would destroy what competition now exists in the delivery of medical care services. There is competition now between the fee-for-service system with its retrospective reimbursement and prepaid group practice plans (PPGPs) with prospective payments and budgeting for health services. The Individual Practice Associations (IPAs) are a competitive response to PPGPs.

PPGPs are most competitive where the benefits and services are comprehensive. This is because the plan can substitute lower cost methods of treatment when appropriate and thereby reduce total costs. A fixed overall budget provides the necessary incentive to use the least expensive form of treatment. For example, there is every reason to transfer a patient from the hospital to a skilled nursing home if medically appropriate. There is every economic incentive to utilize even lower cost home health services in lieu of institutionalization. If equally safe, the PPGP has the motivation to perform surgery on an outpatient rather than on an inpatient basis. If prescription drugs are a covered benefit, unnecessary prescribing of penicillin, which is greatly over-prescribed in the fee-for-service system, is highly unlikely. PPGPs which cover prescription drugs are likely to prescribe generic rather than trade name drugs.

Prepaid group practice plans provide comprehensive health services at a lower cost than an insurance plan providing the same benefits. The premium cost may be as high or higher but the enrolled members have little or no out-of-pocket expense. The ceilings proposed in S. 433 are too low for them to operate without imposing deductibles and/or copayments. To do so, however, weakens the incentives for subscribers to seek early diagnosis and treatment. The bills would thus strip PPGPs of one of their principal advantages for consumers.

On the other hand, if employees had to make additional payments out of their taxable income in order to join a PPGP, the experience of existing plans is that few employees would join them and those who would become members would be most likely to be those who anticipate high health care costs. This problem would be greatly amplified were individual employees able to secure a tax-free refund for selecting a low cost indemnity insurance plan as the bills provide. PPGPs would therefore experience adverse selection making them less competitive.

Mental health is not a required benefit in these bills, but PPGPs can include mental health benefits at low cost because mental patients are high utilizers of physical health services. Studies have clearly indicated mental patients, if treated, use less physical health care. Exclusion of mental health in the competition bills therefore works to the disadvantage of PPGPs because even though they can provide mental health services at relatively low cost, the tight expenditure cap in these bills will probably prevent them from doing so.

Consumer Choice

All of the competition proposals provide for so-called "consumer choice" of health plans. That is, the employer makes a fixed contribution toward the purchase of at least three health insurance plans offered to his employees. If the employer is willing to bear the administrative expense and the nuisance of competitive marketing among his employees, presumably he can offer any number of plans.

The employer provides funds to his supposedly "cost conscious" employees and it is up to them to secure a best buy or a good buy for the money. Employees have freedom to choose whatever they want and providers, doctors and hospitals have the freedom to charge what they want.

There are problems with this simplistic scheme. The patient does not have the necessary information on which to base a rational decision. Try calling up your local medical society to find out what the doctors in your community charge for their services. Try and find out from another source if you wish. It is against professional ethics to advertise, so very few doctors do.

Let it be assumed that our "cost conscious" consumer has tried calling the medical society with predictable results. The consumer then decides to conduct his or her own survey and spends a few hours with the classified telephone directory to find out which physicians are close by and calls them. The consumer will, of course, find a wide variation in office visit charges varying in amount depending upon specialty, the location of the doctors' office, length of time in practice, professional standing in the community, etc.

So our sophisticated consumer finds a doctor who only charges $20 for an office visit instead of the usual $25 or $30. The doctor seems caring and personable. Therefore, the patient is happy. He or she has found a doctor at reasonable cost. Later the patient has a medical problem and makes an appointment. It so happens that the doctor is not too sure and orders $200 of lab tests to confirm the suspected diagnosis. The patient has "saved" $5 or $10 for an office visit and paid out $200 in lab fees which may or may not have been necessary. Does the patient have the medical knowledge to determine whether these tests were necessary?

Or the doctor keeps the patient in the hospital a day longer than necessary at a cost of $300. Does the patient know when it is safe to go home?

This point is stressed because the selection of a doctor is the only choice consumers have with respect to the consumption of medical care services. Once this choice is made, the rest is determined by the physician -- even follow-up visits. Once a doctor-patient relationship has been established, there is a strong emotional bond, like a parent-child relationship. Physicians feel quite strongly that the doctor-patient relationship has therapeutic value and motivates patients to adhere to a treatment regimen.

The patient does not have the information necessary to evaluate the quality of care various doctors provide. The patient has to have faith that the doctor, in fact, is competent. The patient follows the doctor's advice without question as to the necessity for recommended medical or surgical treatment. Most patients consider it bad form to even ask the doctor about fees. Medicine relies on the patient's acceptance of the physician's role as healer.

After all, if a patient is in pain, the patient may feel that going to a doctor may be a matter of life or death. Putting a dollar value on life is impossible, especially when it is your own. Anxiety levels are too high and the expertise of the patient too low to permit rational decision-making at such a time. No matter how much devotees of the market might wish otherwise, medical care consumption decisions are not the same as those consumers make when purchasing most other goods and services.

Deductibles and Coinsurance

These bills accept the theory that consumers have too much insurance and that financial barriers to care will decrease utilization of health services and, therefore, reduce costs. The assumption appears to be that patients should wait until they get very ill and that minor illness never becomes acute. No evidence is offered that deductibles decrease total health care costs. Total health care costs to consumers are the taxes they have to pay for public programs, the premiums they have to pay for private health insurance premiums and the out-of-pocket expense patients have to pay when services are rendered. Deductibles shift the cost from predictable and budgetable prepayment in the form of taxes and health insurance premiums to unpredictable out-of-pocket expenses at the time of illness.

The experience of prepaid group practice plans in the United States lends no support to the theory that first dollar coverage for doctor office visits results in a rush by consumers to doctors' offices. PPGPs with no deductibles or coinsurance have fewer doctor or clinic visits per-person per-year than traditional insurance with deductibles.

The economic theoreticians trained in the "law of supply and demand" refuse to believe in the reality of consumer behavior. If the reality does not conform to theory, they discard reality -- not the theory. The fact is, whether prepaid or not, people do not like to go to doctors, especially when it involves time off from work and docked pay as it does for many workers. If they experience only minor discomfort, they tend to put off an office visit hoping they will feel better later. Or, sometimes fear of the unknown deters them from seeking help. Going to the doctor is inconvenient, time consuming and if pay is reduced, costly.

Moreover, only sixteen percent of the visits to doctor offices are first visits initiated by the patient. All of the rest are initiated by the doctor or made by previously treated patients.

Medical care is not like refrigerators, television sets or coffee. Prepaid care does not result in a queuing at the doctor's door to get something for nothing as prepaid group practice plans have amply demonstrated. But deductibles do deter necessary and early diagnosis and treatment and result in more expensive hospitalization and acute illness. The result is more tax dollars being spent for Medicare and Medicaid, higher premiums for health insurance and higher costs for everybody.

There is no evidence that deductibles reduce unnecessary utilization, but there are studies that show they do deter necessary medical care. These studies show that deductibles and cost-sharing (1) keep the poor from receiving medical services; (2) increase expenditures for hospital care by more than the "savings" of cost-sharing; (3) are ineffective utilization control because physicians, not patients, determine the demand for health services; and (4) are administratively expensive. The most important of these studies confirming the above conclusions was conducted by Dr. Milton I. Roemer and his associates at the University of California at Los Angeles School of Public Health which analyzed the effects of cost-sharing in the California Medical program.

We would also like to cite the experience of the Province of Saskatchewan, Canada. The Canadian national health insurance program forbids deductibles but does allow copayments. In order to "save" money, the Province instituted a $1.50 copayment for doctors' visits in 1968 which resulted in an overall reduction in out-patient services to the poor of 18 percent. Copayments were dropped in 1971.

Dr. R. A. Armstrong, Director General for the Canadian health insurance plan, commented on the copayment experience:

". . . . while these lower income people were

> hit with utilization decreases, after the first year there was an increase in utilization by young single males and females. In other words, the doctors were not going to sit twiddling their thumbs, particularly when they only got paid if they worked."

In short, Canadians know doctors control demand. Some people in the U.S. have not yet awakened to this fact.

Members of Congress should know from personal experience about cost sharing and utilization. They have free care, no financial barriers. They also have better access to care than most other people. Members can see a doctor right here on Capitol Hill. Mr. Chairman, do you or other members of the Congress see the doctor more often just because it is free? Or, do you only go when you don't feel well? We venture to guess that members of Congress see a doctor no more frequently than other people of comparable age and income.

Catastrophic Insurance

In order for an employee health benefit plan to be qualified for tax exclusion, these bills require coverage for catastrophic illness costing more than 20 percent of income (S. 139) $3500 (S. 433) or $2900 (H. R. 850) in uninsured out-of-pocket expenses. Only upper income families could afford to make such payments. For all other families these sums would, in themselves, be catastrophic.

Catastrophic insurance with large deductibles would be of benefit to very few people. In fact, a $3500 catastrophic threshold (plan pays all medical expenses over $3500) would be of benefit to only 26,000 employees in industry or only .08 percent of all employees; at the $2500 threshold level, 44,000 employees would benefit and at the $1500 threshold level, 107,000 or .25 percent of all employees would benefit. This is virtually nothing wrapped in a fancy package. Because catastrophic health insurance helps very few people, the cost of a catastrophic health insurance policy is very cheap.

Catastrophic health insurance has had a trial run in the United States, and that experience demonstrates the high cost of such a program. When the end-stage renal disease program under Medicare became operational in July 1973, the Department of Health, Education and Welfare estimated the cost at $250 million for the first year. Actual costs were $1 billion in 1979.

In 1973, Japan instituted a catastrophic health insurance program to cover dependents of employees and others not covered by employer-employee health benefit plans. Japan's health plan was a catastrophic insurance plan similar to what is proposed in this bill and other bills except that the threshold was much lower. It provided a ceiling of 30,000 yen a month or about $351 a year on copayments.

As a result, the Japanese discovered that the number of high-cost cases -- those costing more than $351 -- doubled in just two years, and the average charge for a high-cost illness increased 21 percent.

This is one reason why catastrophic insurance enjoys support by the Administration and many members of Congress. It sounds good and is cheap in the short-run. But the long-run increase in cost may not be seriously felt for many years.

Vouchers

H. R. 850 proposes to introduce competition between the public and private sectors by allowing each Medicare beneficiary to elect to receive a government voucher which could be applied toward the purchase of a private insurance policy. The vouchers would be for about the same total amount as Medicare now pays. However, the amount of the voucher for each individual would vary depending on whether the individual were disabled or over 65. The aged would be divided into actuarial categories based on age and sex and also by geographic area.

Medicare is not administered by the federal government. It is administered by Blue Cross-Blue Shield and commercial insurance companies such as Aetna, Metropolitan, Prudential, etc., acting as intermediaries which process all Medicare claims and make all payments. However, the intermediaries are regulated by the federal government which performs an oversight role as well. Under this system of regulated private insurance, total costs of administration by both government and the private carriers amount to 3.1 percent of benefit payments. In contrast, the administrative cost of administering private insurance for the under 65 population is more than 12 percent and the insurance companies operate with a varying amount of state regulation and oversight.

It is, therefore, impossible for private insurance to provide identical benefits as Medicare at less cost. What the carriers would inevitably do would be what they do in other public-private competitive programs, such as workers' compensation. They would skim the cream off the top and enroll low-risk Medicare beneficiaries and leave the disabled, those with chronic disease and the oldest beneficiaries to the federal government. Another strategy would likely be to substitute low-cost catastrophic coverage for some of Medicare's basic benefits. The result would be more copayments by the beneficiary and less prepaid insurance.

Medicare beneficiaries would be bombarded with literature from hundreds of insurance companies each claiming to be the best. If some of the older people were taken in by the propaganda, they might not be able to go back to Medicare because H. R. 850 has a provision that once a beneficiary elects out of Medicare, he or she cannot return. In the end, the insurance companies would be operating Medicare without any federal regulation or oversight. The result would be increasing administrative costs and rising premiums at an even faster rate than at present.

Regulation

Many supporters of these proposals have uncritically accepted the rhetoric that the proposals would establish a medical "free market" as an alternative to "regulation." But, in fact, the bills provide for regulation to make competing insurers follow the same rules regarding the design of premiums, benefit packages and quality of care. Each of the "pro-competitive" proposals would require the replacement of existing regulations with a regulatory structure equally or more complex.

H.R. 433 and S. 139 are skeleton bills. H.R. 850 actually comes to grips with some of the regulatory problems that would arise.

It is instructive to read the text of H.R. 850 from the point of view of what would be required in the way of regulation. The bill provides federal assistance to individuals living below the poverty line in the form of vouchers. Since Medicaid eligibles are only one-half of the poverty population, the means test would necessarily have to be extended to many millions of persons not now eligible for free medical care. Moreover, the amount of the voucher would depend upon income thereby increasing regulation and its cost. This is but one example.

Another is that H.R. 850 would establish different ceilings in different health service areas to take into account geographical variations in health care costs. The complexity of defining such areas in an equitable manner would also require regulation.

But these are only a couple of examples of regulations the bill requires. *The words: the Secretary determines or determined* by the Secretary, the Secretary provides or provided by the Secretary, the Secretary establishes or established by the Secretary, the Secretary delineates or delineated by the Secretary, the Secretary specifies or specified by the Secretary occur over 60 times. We have closely examined the bill and have found that every one of those provisions requires detailed regulation. Thus the issue is not regulation or no regulation. It is a choice of two sets of regulations with different objectives.

Tax Consequences

These "competition" bills would all require a ceiling on employer contributions to an employee health benefit plan. Employees, union and non-union alike, desire comprehensive benefits enabling them to avoid unpredictable medical expenses which so often arise when the family can least afford it. Deductibles, co-payments and inadequate coverage have been resisted by unions for many years because comprehensive benefits are what the membership wants. Attempts by employers to impose deductibles or to reduce benefits have caused strikes in a number of industries. Unions are determined to preserve the gains won over many years through collective bargaining and will strongly resist any attempts to take away these gains by legislation. Our members want more insurance, not less.

Offering a low-cost plan with a tax-free rebate would have appeal to some young, healthy workers. The older worker, particularly one with chronic disease or handicapped, would need a comprehensive plan.

This would cause adverse selection making the cost of the comprehensive plan progressively higher. Simultaneously, it would raise the taxes of the elderly because their premiums would exceed the allowable ceiling.

Tax rebates for the young, tax increases for the old. This is a prescription for inter-generational feuding.

The ceiling or cap on employer contributions that would be subject to tax exemption as provided by these bills increases the taxable income of employees who choose comprehensive health benefit plans. The result would be a tax increase for many working people, particularly for older workers which would take away some or all of the tax cut recently legislated.

The amount of the tax increase would depend upon the comprehensiveness of the health insurance coverage the employee has and, of course, on the amount of the ceiling. If the cap were set at $125 a month for a family and $50 a month for a single person as in H.R. 433, a family of four with the average income of $21,000 a year would have to pay $114 in additional taxes in 1981. This assumes an employer contribution for health insurance of $140 a month per employee. That same average family received a reduction of $228 in their taxes as a result of the recently passed tax cut. One-half of the tax cut would be taken away. Many families with incomes below the average and many large families would lose their entire tax cut if this legislation is enacted.

Attached as an Appendix is a table showing the amount of additional tax that a family of four would have to pay at various employer contribution levels.

Conclusion

Mr. Chairman, we find it difficult to find the appropriate word to describe the theory of these bills: fanciful? unreal? illusory? visionary? absurd? It totally ignores physician dominance of the medical market. It demonstrates an extraordinary ignorance of how consumers behave when confronted with illness. It assumes delay in seeking medical care will save money. It fails to recognize that channeling more funds into high cost technological care at the expense of health maintenance services will accelerate the escalation in health care costs. It incorrectly assumes competition will eliminate the need for regulation of providers and insurers.

For the family of four with average income, these competition proposals would take away one-half of the recently enacted tax cut. For larger and/or lower income families, the competition bills would take back all of the cut.

The AFL-CIO strongly opposes these bills and any others that may be introduced which are based upon the same faulty theory.

Appendix

TABLE

Additional Tax Per-Employee if Competition Bill Passes*

Employer Contribution Per Mo. Per Employee	Contribution Per Mo. Per Family	Additional Taxable Income Per Employee Per Year	Additional Tax Per Employee Per Year
$100	$125	$ 0	$ 0
120	150	300	57
140	175	600	114
160	200	900	171

If a "competition" health bill were enacted with the $125 ceiling on the employer contribution for a family, the employer making a $140 contribution per employee each month translates into $114 of additional taxes for the average worker earning about $21,000 per year. The same average worker will receive a reduction of $228 in his taxes as a result of the Reagan tax cut. In short, one-half of the tax cut would be taken away. A worker with less than average income could lose all of his tax reduction. The competition bills amount to an additional and regressive tax.

*Assumes a family of four with one wage earner earning the median income of about $21,000 in the 19 percent tax bracket.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, COMMITTEE FOR NATIONAL HEALTH INSURANCE, ON BEHALF OF DOUGLAS A. FRASER, CHAIRMAN

Mr. **Glasser**. Mr. Chairman, I am Melvin A. Glasser. I represent the Committee for National Health Insurance. Douglas Fraser, the chairman, regrets he could not be here. There were transportation problems.

The United Auto Workers joins in support of this statement, which I ask be included in the record, the full statement.

Chairman **Jacobs**. Did you say there were transportation problems?

Mr. **Glasser**. For Mr. Fraser.

Chairman **Jacobs**. For the president of what union?

Mr. **Glasser**. The United Auto Workers Union makes transportation vehicles. It doesn't supply transportation.

Chairman **Jacobs**. Thank you.

Mr. **Glasser**. When proponents of these so-called competition plans first advanced them, they were called consumer choice plans. More recently the term has been largely abandoned, and with good reason. No consumer organization supports them. The labor movement is opposed to them. So is the commercial health insurance industry, the major employer organizations, spokesmen for organized medicine, the poor, disabled, and the elderly.

Public health experts are appalled by these proposals and administrators of teaching hospitals are alarmed. All have good reason for their concern because the advocates of these proposals turn out to be those who are working on the basis of flawed understanding of America's health care system and erroneous assumptions.

I shall touch on them very quickly. They are outlined more fully in my full statement.

First, a primary assumption of the sponsors of these proposals is that there is not enough competition in health care today. But we don't have a shortage of health care competition today. We have too much of it, with wasteful duplication of sales forces, claims services, reserve funds, et cetera.

There are more than 600 companies that write group health insurance. The largest has only 4 percent of the business. Approximately 95 percent of so-called new group policies of commercial companies are not new at all. They are transfers from one company to another as a result of competition.

Second, these so-called competition plans are not health insurance programs. They are "have less" plans, as was explained this morning. They assure that fewer people will have insurance protection than today, and those that do have insurance will pay more to get fewer benefits. They are "have less" plans, Mr. Chairman.

If you pardon an aside, if I say if they really want to save money for the program, if they really want to provide less insurance, let's do it right. Let's abandon all insurance. It will save a lot of money for the insurance industry and the Government, and we can go back to the 1920's, if that is what they are after.

Third, increased costs would accrue to workers, and union negotiated contracts would be undermined. It is a very serious problem. To fit with the tax cap, deductibles and coinsurance would be added to programs which do not now have them. Attempts by employers to accomplish this have been factors in strikes in the auto, mine workers and other industries, and there will be more.

The plans would exclude two of the principal forces needed to contain costs. H.R. 850 excludes employers and unions, the two potentially powerful forces that can do this.

Thus, the insurance companies, not the politically powerful employers and unions, are expected to hold down costs.

There is absolutely no evidence over some 35 years of experience that they have been able to do this. Unions among smaller employers would find it difficult to take from low wages for high cost premiums. Incentives would be there, therefore, to drop all coverage and substitute more wages for fringe benefits.

Health and welfare plans not mentioned in anything until now which now use their clout to bargain the best possible insurance deal among insurance companies or self-insure to get the most per dollar would no longer be able to do this under these plans, and unions with decent health plans would find their benefits seriously eroded.

For example, Mr. Gephardt's H.R. 850 has a grandfather clause which exempts from tax liability health benefits in current contracts, and freezes them until the tax cap, indexed for inflation each year, catches up.

In essence, this means that if present health care inflation trends continue, in about 5 years comprehensive union health plans would have protection for only one-half of the benefits they have today.

Fourth, deductibles and copayments are harmful and will not work, as Mr. Seidman has indicated. Their principal effect is simply to shift costs to the patient.

Fifth, the assumption that people will choose among insurance plans largely on the basis of price is not supported by the facts and they are amplified in my testimony.

Sixth, consumers do not have the knowledge to choose among a multitude of health insurance plans.

Seventh, aggregate costs of competition plans will be higher, not lower. Many advocates of these plans suggest that high and low cost option plans be offered with cash rebates to workers who select options which are low. They suggest this will save money. In reality, it will cost a good deal more.

This is due to the phenomenon of adverse selection which has been talked about. The young and healthy would be likely to select the low option plans. The older and chronically ill, knowing they will need services, will select the high option plans. The premiums of the high options rise, low options go down, cash rebates increase, total costs go up. Senior citizens and the poor would be harmed.

Finally, I want to indicate that competition plans are basically revenue raising measures and should be seen for that. It is perhaps the least understood aspect of these plans.

By undermining the private and public insurance programs, the Federal Government with tax caps would gain huge new revenues to spend for purposes other than health. The reliable estimates, some of which you heard this morning, indicate that if S. 433 were passed, the Federal Government in the first year of operation, 1984, would obtain $4.1 billion in new revenues. By 1986 the new tax revenues would be $9.4 billion. If it became effective in 1982, the first year revenues would be $2.3 billion.

These clearly indicate the inequities, particularly because these taxes would more heavily fall on those in the lower income brackets.

Finally, I would like to conclude, since we have heard testimony about economics and guesses about how things would happen, with a quote from the distinguished Harvard Medical School economist Dr. Rashi Fein.

> To call less insurance, experience rating, selection of risks competition is to do violence to the English language. Worse than that, it is to do violence to the concepts and the goal of equity. To control health care costs by rationing people out of the health care system is akin to solving our problems by denying them away, or in the words of the New York Times headline some years ago, "Poland Raises Meat Prices. Announces Shortages Solved."

The market is a control mechanism, but hardly the appropriate one in medical care.

Thank you, Mr Chairman.

[The prepared statement of Mr. Fraser follows:]

STATEMENT OF DOUGLAS A. FRASER, CHAIRMAN, COMMITTEE FOR NATIONAL HEALTH INSURANCE

Mr. Chairman, my name is Douglas A. Fraser. I appear before you today in behalf of the Committee for National Health Insurance. With me today is Melvin A. Glasser, Director of the Committee.

I appreciate the opportunity to present to this Committee our views on legislative proposals, such as H.R. 850, S. 139, and S. 433, which purport to solve the serious ills of our nation's health care system by attempting to stimulate competitive marketplace forces. We believe that, in reality, such so-called "competition" or "consumer choice" legislation not only would fail to achieve the intended goals, but would reverse decades of progress in extending health insurance protection to millions of Americans through collective bargaining programs and through public plans such as Medicare and Medicaid.

Those advancing the so-called "competition" approach apparently see it as a replacement for the national, state and local health planning system, and as a substitute for meaningful program standards, which they would like to eliminate from many health insurance plans, public and private. Others propose this approach as a substitute for national health insurance, which of course it is not.

When proponents of these so-called competition plans first advanced them they were called "consumer choice" plans. More recently the term has been largely abandoned, and with good reason. No consumer organization supports them. The labor movement is opposed to them; so is the commercial health insurance industry, the major employer organizations, spokesmen for organized medicine, the poor, the disabled and the elderly. Public health experts are appalled by these proposals; administrators of teaching hospitals are alarmed.

And all have good reason for their concerns. These plans, when seen for what they really are, turn out to be based on flawed understanding of America's health care system and erroneous assumptions.

(1) A primary assumption of the sponsors of these proposals is that there is not enough competition in health care today. Insurers competing on a price basis will pressure providers for better prices. But we don't have a shortage of insurance industry competition—we have too much of it—with wasteful duplication of sales forces, claims services, reserve funds, etc. More than 600 companies write group health insurance. The largest, according to the Health Insurance Association of America, has only 4 percent of the business. Approximately, 95 percent of "new" group policies of commercial companies aren't new at all; they are transfers from one company to another as a result of competition.

(2) These are not health insurance programs; they are "have less" plans. They assure that fewer people will have insurance protection than today. And those that do have insurance will pay more to get fewer benefits. Through requirements that standard packages of benefits be offered, increasing costs for establishments with smaller number of workers, making the plans voluntary, and removing both em-

ployers and unions from decision making roles, these plans are highly likely to see more people removed from even the inadequate coverage many of them now have.

(3) Increased costs would accrue to workers, and union negotiated contracts would be undermined. The Competition approach would turn back the clock on decades of progress in collective bargaining. To fit with the tax cap, deductibles and co-insurance would be added to programs which do not now have them. Attempts by employers to accomplish this have been factors in strikes in the auto and mine workers industries and elsewhere.

And the plans would exclude two of the principal forces needed to contain costs. H.R. 850 excludes employers and unions, two potentially powerful forces for cost containment. The UAW for example has been working on cost containment for 13 years—eight of them with employer cooperation. Both would be excluded from any role in the selection of workers' health plans. Employers are required to let individual workers choose from among all federally qualified health plans marketed in their area. If they don't do this, they lose their tax exclusion.

Thus the insurance companies, not the politically powerful employers and unions are expected to hold down costs. There is no evidence they have been able to do so to date. On the contrary one would expect them to offer more low costs, low utilization services as carrots. And the unions, until now the major developers of benefits and cost containment, along with employers, are largely removed from an effective role.

Unions among smaller employers would find it difficult to take from low wages for high cost premiums. Incentives would be there therefore to drop all coverage and substitute more wages for these fringe benefits.

Health and welfare plans which now use their clout to bargain the best possible insurance deal among insurance companies, or self-insure to get most per dollar, would no longer be able to do this.

And unions with decent health plans would find their benefits severely eroded. For example H.R. 850 has a "grandfather" clause which exempts from tax liability health benefits in current contracts, and freezes them until the tax cap, indexed for inflation, each year catches up. In essence this means, if present health care inflation trends continue, in about five years, comprehensive union health programs would have protection for only about half the benefits they had when H.R. 850 became operative.

(4) Deductibles and co-payments are harmful and will not work. One of the thrusts of these plans is expanded incentives for deductibles and co-payments. They are seen as reducing unnecessary demands. It is argued that if the patient's price consciousness is increased he/she will make informed, rational choices among alternative forms of treatment. Employers make such arguments to us in collective bargaining. We have succeeded in rejecting them for our principal benefits because our own experiences are consistent with the findings of research studies:

(a) the principle effect of cost sharing is not cost containment, but transfer of costs directly to patient from the insurance company and the employer.

(b) patient cost sharing can serve as a barrier to early treatment and can actually increase costs, because more expensive treatment may be required for conditions which have worsened due to delay of care.

(c) and the patient has very little control. After he/she makes a decision to go to the doctor, virtually all decisions about what services are to be given are made by doctors and other health care providers. It is estimated that 70 percent of personal health care costs are physician generated. It is the doctor who admits the patient to the hospital and determines how long he/she will stay. It is the doctor who prescribes drugs not the patient. It is the doctor who orders X-rays and lab tests. The patient does not have sufficient medical knowledge to make choices among alternative forms of treatment and to weigh the costs and benefits of each.

(d) cost sharing has been shown to have almost no effect on the prices doctors and hospitals place on their services. Generally, providers decide the price of their services, not some free market.

(e) patient cost sharing discourages access to care by lower income persons. Experience has shown that the burden of cost sharing falls unfairly on the poor, on the blue-collar workers, on minorities, and on those with large families.

(5) The assumption that people will choose among insurance plans largely on the basis of price is not supported by the facts. "Competition" advocates talk about "the invisible hand of competition" regulating the marketplace. They see consumers selecting those plans and those providers in the same way they choose refrigerators, television sets, or brands of coffee. They are wrong, both in theory and in practice. They misread Adam Smith. If they will look again at his "Wealth of Nations" they will find Smith states that in medicine and in law there is so much at stake that

price has much less importance than in commercial markets. People do not seek the cheapest according to Smith, they seek the best.

For example, under the federal employees plan, almost 90 percent chose the high comprehensive plan when the cost to them is almost twice the low option plan. The Blue Cross/Blue Shield organizations which have price advantages due to their arrangements with hospitals and the tax free status of their premiums, have steadily lost business to the commercial insurance industry. Today, they have less than one-half of all the business. So other factors like the nature and comprehensiveness of benefits, service, the handling of claims, clearly play a major role.

(6) Consumers do not have the knowledge to choose among a multitude of health insurance plans.

Central to the functioning of these "competition" proposals is that each potential subscriber will be offered a number of insurance plans. He or she will then choose the plan that is "right" for him.

This kind of system cannot possibly work. The consumer is in no position to understand or judge the vast variety of complex insurance plans. And if he guesses wrong he may end up with a disastrous financial burden.

That the consumer doesn't know how to make such decisions is demonstrated by two experiences:

(1) Millions of Americans each year purchase so called "dread disease" or "cancer indemnity" or questionable "medicare fill" policies. Congressional committees, state insurance commissioners and others have publicly questioned the soundess of many of these plans. Yet their sales continue to flourish.

(2) Recently two major reputable insurance companies competed for the almost three million policies of members of the American Association of Retired Persons. They spent huge sums "educating" potential customers in this organization. Yet when the Washington Post took the competing policies to health insurance experts and actuaries they told the Post they could not make a sound recommendation of what would be best for each individual . . . the individual variable were too great.

(7) Aggregate costs of competition plans will be higher, not lower. Many advocates of these programs suggests that high and low cost option programs be offered, with cash rebates to workers who select low options. They suggest this will save money. In reality, it will cost a good deal more than the inflationary status quo. What would result is the phenomenon of adverse selection. The young and healthy would be more likely to select low option programs and receive cash rebates. The older and chronically ill knowing they will need many services will select the high option plans. The rebate is part of the total plan cost. The premiums of high cost plans would rise because of adverse experience; the premiums of low cost plans would fall. Over time the effect would be amplified. The gap separating premiums would widen and the rebate would continue to increase. No one has yet suggested an administratively feasible solution to this additional inflator of health care costs.

(8) Senior citizens and the disabled would be harmed. The effect of some of these proposals would mofify or substitute a purchase voucher for the Medicare program. Others would include the Medicaid program as well. Recipients would be given these vouchers to enable them to purchase health care coverage from private insurance companies in the so-called "competitive marketplace". This would represent an abdication of responsibility by the government for dealing with the problems of access to care, quality of care and cost containment—especially, with regard to the more vulnerable members of society.

This is particularly unjust because it assumes each individual will have an "average" health bill. This is obviously untrue. If a Medicare recipient receives a voucher worth approximately $1,700, the present average cost of Medicare per recipient, it is hardly likely this would go very far to cover the cost of the treatment of cancer or serious heart disease. Serious chronic illness is a problem for about half of the elderly. Medical vouchers are a means to turn society's back on their needs.

(9) Competition plans are revenue raising measures. This is perhaps the least understood of any of the aspects of these plans. By undermining the private and public insurance programs, the federal government with the tax caps would gain huge new revenues to spend for purposes other than health. Reliable estimates made by objective governmental sources indicate that if S. 433 were passed, the federal government, in the first year of its operation, 1984, would obain $4.1 Billion in new tax revenues. By 1981, new tax revenues would be $9.4 Billion for the year. If S. 433 were modified to make it effective in 1982, the first year new revenues would be $2.3 Billion; by 1984 the revenue gain would be $5.5 Billion.

These numbers are huge and clearly indicate that we are talking here about less insurance coverage, more consumer payments and huge new tax gains for the federal government at the expense primarily of middle class and working people. The labor movement, civil rights and other organizations, protested vehemently, and in vain, that the Administration tax bill passed by this Congress disproportionately favored upper income groups. These "competition" plans would further aggravate the situation by adding new taxes for health care on those at the lower end of the economic ladder. Again they would be required to pay proportionately more of their incomes for new government revenues than those in the upper income brackets.

(10) Regulation—There would be no decrease in regulation. The pro-competition approach would not lead to less government regulation. Such an attempt to restructure the industry along marketplace lines would require massive governmental action. All of the bills add significant power to the government while taking some away. HR 850 for example has over 60 references to decisions or regulations which would be made or issued by the Secretary of Health and Human Services. In addition, a whole new health arbitration legal structure would be constructed. So the real issue is not between regulation and less regulation, but between old regulations and new ones. The inherent instability of the "competition" approach will inevitably require over increasing regulation.

The vexing problem of an American health care system in disarray can only be solved by a national health security program based on six principles:

(a) Coverage of all persons as a matter of right;
(b) Comprehensive benefits;
(c) Reform of the way in which services are organized and paid for;
(d) Workable cost and quality controls;
(e) Elimination of a two-class system of care;
(f) Accountability to public and consumer interests.

In concluding it is appropriate to quote distinghished Harvard Medical School Economist Dr. Rashi Fein: "To call less insurance, experience rating, selection of risks "Competition" is to do violence to the English language. Worse than that: it is to do violence to the concept and the goal of equity. To control health care costs by rationing people out of the health care system is akin to solving our problems by defining them away, or in the words of N.Y. Times headline some years ago, "Poland Raises Meat Prices. Announces Shortage Solved." The market is a control mechanism but hardly the appropriate one in medical care.

STATEMENT OF CATHY SCHOEN, SPECIAL ASSISTANT TO THE PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

Ms. SCHOEN. I am Cathy Schoen, special assistant to the president of the Service Employees International Union.

On behalf of our 675,000 members and President John Sweeney, I thank you for this opportunity to testify on the proposals commonly called, and we feel incorrectly called, competition plans for health care. I will be summarizing our lengthy written comments. We request the full statement appear in the record.

As low-wage workers in the service sector of our economy, SEIU members struggle each year to achieve the decent standard of living and health care which is the promise this Nation has always extended to those willing and able to work.

Most of our members have only recently gained access to high quality and relatively comprehensive health plans. In fact, before coming here today I reviewed many of our policies and almost all of them are under the caps you are proposing today.

We are coming here because we are concerned about health care costs. With wages averaging $4 to $6, health insurance benefits are taking 15 to 20 percent of the contract packages we negotiate each year. Our members must trade off desperately needed increases in pensions and wages, just to maintain minimal health care coverage.

We do feel the impact of high costs of care. We are not protected from it. Many of our members in hospitals and nursing homes each day find they can't afford to pay for care that they are delivering.

They are turning away other people who are uninsured or inadequately insured, and unable to pay for care.

The price we pay each year for protection against the cost of possible illness long ago led us to work for the enactment of national health insurance. We have even supported and strongly supported hospital cost containment legislation, even though these controls would place some restraints on our contract bargaining.

At the same time, we are concerned that the proposals you are considering today would not save costs and would hurt our members. We fear specifically that they will be a vehicle not for lower costs, but for lower public budgets, where the poor and working people would once again be asked to sacrifice while the well-to-do can do as they please.

We feel we are moving backward rather than forward with these proposals.

I want to summarize briefly the major points we make in our written testimony to explain why we see these proposals would have a negative impact.

First, we believe the proposals would increase rather than decrease costs. People have mentioned this, but I want to give you some specific examples.

The proposal to limit the tax deductibility would clearly shift on to workers' backs the current costs of premiums. This ought to force people to choose less insurance. But it would also, when coupled with multiple choice requirements, fragment current coverage of care.

One of the few leverages we have right now are our union trust funds. Because we are concerned with costs, SEIU has been very active in trying to control costs in these plans using the group leverage. We find as individual consumers we have no leverage.

We need the power of the group to be able to do something in the market. Multiple choice would destroy these plans. I can give you one example that they do work.

We have a local in New York that covers workers and their families, 120,000 members in a trust fund plan. This local has been able—by self-administering and offering one option, not multiple options, not to each individual worker—to control costs so effectively that they have held down costs below the level the insurance company we were previously using quoted us as a premium price 5 years ago.

No insurance plan can match our low costs today. We have been able to offer expanded benefits with our savings. We do keep the dollar savings, contrary to what Dr. Havighurst said before. We either use them for pensions or expanded benefits. Thus, we have an incentive to keep costs down. These multiple choice requirements would destroy the potential of group controls.

Second, the fragmentation by making much smaller group coverages would raise what I would call unnecessary costs of health insurance, high underwriting costs, marketing costs, and administrative costs.

A table in our testimony shows that the average individual plan returns only 54 cents for every premium dollar, where the labor-management plans are returning 98 cents, and the large group plans are returning 91 cents.

This dramatic difference in performance results from the expense of marketing to an individual consumer rather than a group, and not knowing what your group is going to be.

The major cost increasing impact would come from the loss of public control and leverage. Although we don't use much of this leverage right now, the major reason that there have been protests about excessive government interference, we believe, is that there exists a potential to use this leverage.

In the hospital business, public programs, medicare, medicaid and other public funds currently pay for 55 percent of all costs; nursing homes, 56 percent. If you break up these plans with voucher programs, individual coverage, you lose the leverage you get by having everyone in one group. You lose one of the few countervailing powers that now exist against strong provider control.

Second, we believe the proposals would clearly increase access barriers, discrimination, and potentially result in greater disease and suffering in this country. One of the things that these programs seem to forget is that not everyone has access to care right now, and that one of the reasons we try to insure is to make sure we don't make a decision whether or not to have care based on price, but whether or not it is effective.

These gaps in coverage have caused a huge medicare fraud problem in this country when elderly citizens try to fill in gaps in the program. People really try to remove those barriers. These voucher proposals would turn that clock back.

Discrimination in health insurance plans would result because the health insurers would find the most profitable way to market plans would be to divide up people, divide younger from older workers, black from white, healthy from nonhealthy, workers in unhealthy industries in healthier industries.

There is really no way of fine-tuning to guard against such marketing schemes. Even if you start talking about very small health areas to calculate premiums, you cannot get at this differential health need, and discrimination would result.

Again, in health status, our written comments show that health insurance has in fact increased and improved health status. The United States has achieved dramatic improvements in infant mortality rates, chronic care conditions, since the advent of medicare and medicaid and private insurance.

When you talk about rolling back insurance coverage, you talk about risking people's health. There is a direct relationship.

Finally, let me just briefly list the other points here, since I don't have time to go into detail. As mentioned before, we believe the proposals would impose a regulatory nightmare on the economy. The proposals also encourage a regressive and an unwieldy change in tax policy. If you want to administer the cap correctly.

The proposals would restrict our freedom of choice. We can choose what we want now. We are going to be told you cannot have a union trust fund anymore, you have to have multiple choice, you cannot have a big public program anymore, we are turning it over to vouchers.

Finally, on the voucher system, not only do you lose public control when you go to vouchers, but you risk destroying one of the few protections we have for elderly and poor people in this country.

You destory the one comprehensive plan that can bargain on their behalf for access to care.

Many of our members work in public hospitals which depend desperately on these funds for coverage. Any cost savings to the Federal Government would translate into bankruptcy for these facilities, innercity and public facilities.

Nowhere in these plans is there any provision to pick up what Clark Havighurst called market failures. What are you going to do with the large uninsured populations if public hospitals are bankrupted by a loss of medicare and medicaid revenues?

Again, on behalf of all of us for the opportunity to testify today, we thank you. We hope that beginning testimony now before there is an administration proposal will increase broad public awareness of what we feel to be the destructive content behind the competition label that has been put on these plans.

[The prepared statement follows:]

STATEMENT OF THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

Good Morning. Mr. Chairman and Committee Members. My name is Cathy Schoen, Special Assistant to the President of the Service Employees International Union.

On behalf of SEIU's 675,000 members and our President, John J. Sweeney, I thank you for this opportunity to testify on the proposals which are commonly known as "competition" plans for health care.

It has been apparent for some time that the Administration's agenda for health went way beyond changes in financing. As drastic as their proposals were to cut government support for health care delivery, their plan for systemic changes is more significant. While the Administration has pushed back its target date for its own legislation, the proposals before you today contain many of the elements which will be in the Administration's bill when it is put forward. We in the health care workers union of the AFL-CIO think you are performing a public service by taking testimony from diverse points of view at this time.

As low-wage workers in the service sector of our economy, SEIU members struggle each year to achieve the decent standard of living and health which is the promise this nation has always extended to those willing and able to work. As staff of our health facilities--where some 230,000 of our members work--we know first-hand the realities and deficiencies of health care in America.

Workers throughout the service sector are deeply concerned about today's high and rising costs of health care. Most only recently have gained access to high quality, relatively comprehensive health care coverage. In fact, most SEIU plans would be under proposed limits on tax exemptions.

Even where we have bargained successfully for decent health care coverage, it comes at a high cost and sacrifice. With wages averaging $4.00 to $6.00 per hour, even a relatively minimum basic benefit package comes to 15 to 20 percent of our annual incomes. This, coupled with a premium rate inflation of 20 percent, forces us to forego much needed pension and wage improvements just to maintain our access to decent health care services. Real weekly earnings are down 12% over the past five years. Yet each year employer contributions to our health plans absorb more of our total contract gains.

Many of our members in hospitals and nursing homes still cannot afford to pay for the care they deliver each day. And both nurses and admitting clerks tell stories of people turned away from private facilities and sent to public ones because they couldn't pay for desperately needed care.

The price we pay each year for protection against the costs of a possible illness and for access to decent care long ago impelled us to work for enactment of national health care legislation which would guarantee all residents access to decent care. We have, in addition, strongly supported hospital cost containment legislation even though controls would place some restraints on our contract bargaining. The problem of escalating health costs is so large and access to health care such an important issue that it requires everyone involved--doctors, consumers and nurse's aides--to work for a rational, humane and affordable way to provide healthcare.

The health system in America today is noncompetitive. Dominated by wealthy insurance companies, high-profit high-technology firms and powerful provider organizations, it is all too often characterized by a coziness among interest groups that works to the detriment of the consumer. It could well use a dose of healthy competition.

SEIU has long advocated such change. Our local unions throughout the country are involved in health maintenance organizations, alternative care mechanisms funded by union health and welfare monies that deliver care at lower than prevailing rates, and consumer-union alliances to fight anti-competitive practices and improve comsumer health information and education.

We believe that anti-trust action in health care may be a good vehicle for the creation of such an environment. While anti-trust also presents some difficulties, it may be one good way of getting insurance companies, including Blue Cross, to start acting as aggressive representatives of consumers, using their enormous purchasing power to hold down medical prices.

At the same time we are concerned with the substantial impact, and potential for change of the present proposals. We fear, specifically, that they will be a vehicle not for lower costs, but for a lower public budget, where the poor and working people would once again be asked to sacrifice while the well-to-do do as they please.

There are a lot of holes developing in the Administration's vaunted safety net these days. We are concerned that "competition" might turn into a gash in that net big enough to drive a truck through. It is not an exaggeration to describe much of the current competition proposals more accurately as anti-insurance.

We are dismayed and horrified to find that instead of moving forward on the debate on what to do about the organization and financing of health care, we appear to be moving backwards. Under the guise of promoting competition we are now considering proposals to decrease health insurance coverage, make the elderly, workers, and low income families pay more out of pocket when they seek care, and remove what little public control we have over prices, quality and costs. To harness inflation these plans want to saddle patients with higher costs of care, a cruel and ultimately ineffective burden that will fall most heavily on those least able to bear the cost.

In our discussion of these misnamed competition proposals we discuss generally why these proposals will hurt our health care system. Specifically, we explain why we believe the proposals will:

1. Increase rather than decrease costs.
2. Promote unequal access to care, discriminatory market practices, and ultimately reverse recent progress in improving health status.
3. Create a regulatory nightmare.
4. Restrict our current freedom to choose the best plan to fit our needs.
5. Impose a regressive and unwieldy change in tax policy.
6. Remove essential public control and guarantees of coverage for our elderly and low income populations.

Anti-Insurance Proposals: Myth of the Marketplace

The proposals which collectively call themselves "competition" proposals basically advocate less health insurance as the solution for rapidly rising health care costs. Most of these proposals share three basic elements to one degree or another:

1. A limit to the tax deductibility of an employer's contribution to each worker's health coverage. "Excess" insurance or coverage payments would become taxable income to workers.

2. A requirement that employers offer individual workers a choice of health care plans, irrespective of collective bargaining agreements or previous employer arrangements for health coverage or funding. (With rebates for choice of low option plans in some proposals).
3. Transformation of Medicare and Medicaid from publicly controlled health care plans to individual vouchers to purchase private health plans.

The expected (and likely) impact of these three features would be to increase the direct costs of health care by inducing individuals and families to purchase less comprehensive health care coverage or suffer the tax consequences.

Advocates of such proposals assert that they can somehow fine tune the roll back in health insurance coverage to avoid erecting major barriers to necessary care for lower income families. They reason that although they do indeed want consumers to pay more out-of-pocket, the resulting "new" consumer cost consciousness will bring down costs of care with no sacrifice of quality, equity or access to care .

These claims are based on a mythical medical marketplace which has never existed in this or any other country.

The anti-insurance proposals all start with the assertion that the reason health care expenditure inflation consistently exceeds the rate of GNP growth and general price increase is that consumers have too much health insurance. If people were more exposed to the costs of services when they receive them (rather than pre-paying through insurance premiums), the anti-insurance advocates believe that patients would be more aggressive in shopping around for a health plan which held down costs and in challenging physician and hospital decisions to order more or more expensive services. Patient pressure would in turn make insurers more aggressive in policing provider price and service increases, encouraging new cost conscious organizational arrangements. Finally, the advocates believe that physicians and hospitals will respond to less insurance and more aggressive patient/insurer companies by moderating price increases and changing the style of medical practice to put more emphasis on prevention and avoiding of marginally beneficial (or even potentially) harmful services. Advocates commonly make analogies to the purchase of cars or other consumer goods to illustrate the way the health care market would work out its problem through competition for patient dollars.

This deceptively simple theory basically holds that greater consumer "sensitivity" to costs of care would make us all shop more vigorously for the ideal insurance plan and that insurers would be eagerly waiting to drive hard bargains over fees, stop unnecessary surgery, reduce hospital days and excessive tests all in order to be the low bidder for our business. Notably these are all efforts insurers are unwilling to undertake today.

This theory ignores the reality of healthcare markets. Contrary to the blame these proposals place on health insurance, we note that, as Table 1 illustrates, long before the widespread use of health insurance, health care price inflation exceeded the rate of general inflation. People then, as today, followed the doctor's orders even if they had to go into debt. Recent hearings of consumer horror stories of our senior citizens buying several worthless private policies in a vain attempt to fill the gaps left by Medicare are vivid testimony that most of us will pay dearly to allow us and our families to decide whether or not to have an operation based on the medical efficacy of the operation rather than the cost. We know that when faced with decisions based on price we often choose wrong. We choose too much surgery; too little preventive care.

Most of us readily acknowledge that we lack the knowledge, sophistication or confidence to challenge a medical professional's opinion about our health care needs. We make the decision to go to the doctor--usually putting it off as long as possible. After that, the decisions are in the doctor's hands. And in the hospitals, where the most expensive decisions are made, patients and their families are in no condition to challenge or question an expense, even _if_ the thought occurred to them.

Unlike the anti-insurance proponents our members are unwilling to risk a wrong decision; they don't buy health care the way they buy applicances--by the price.

Time after time we hear stories from our members of second mortgages on homes, borrowing from relatives, exhausting savings to follow the doctor's orders. And these families consider themselves lucky because they could afford the care. Less insurance wouldn't change this picture. It would simply mean more of a burden on the family struck by illness or injury and more regressive financing of care.

Not only does this myth of a competitive marketplace have a distorted view of patient/insurance/provider relationships, the theories evidence a basic lack of understanding about why health care is so expensive. Nowhere do we find mention of the estimated $6 billion in excessive surgery in 1978; the excessive use of hospitals which adds $5 to $10 billion to costs each year; the proliferation of expensive, diagnostic and treatment equipment; the fact that despite an increasing surplus of doctors in many of our cities, each doctor appears able to generate enough new services to maintain a steady rise in physician incomes. And all of this is occurring in a world where patients under 65 pay 36 percent of medical and surgery costs directly and Medicare on average picks up only 44 percent of the costs of care for the elderly, and this percentage is declining. (See Table 2).

Patient-initiated (demanded) care is not the stimulus for high and rising costs. Rather, it is provider decision on how to care for our sickest and most frail families that causes costs to soar. Even Medicare, which serves a population generally with high health care needs, exhibits a dramatically skewed distribution of expenses. As Table 3 illustrates, although the average hospital payment for beneficiaries over 65 ran $636.00 in 1978, 40 percent had no expenditures while 9 percent averaged more than $3,000 in expenses.

Anti-Insurance/Competition Proposals will Increase Costs

This fundamentally distorted view of the health care world has led the anti-insurance/competition advocates to introduce legislative proposals which would raise rather than lower costs. In addition to the obvious increase of cost for some workers in the form of taxation of comprehensive health plans, health care costs are likely to increase for four reasons:

1. Forcing multiple individual choice will destroy current group cost controls, especially self-funded employer and union health and welfare trust funds.

   Contrary to the myth of individual consumers shopping around for care, we at SEIU, like others around the country, have learned that organized consumers make much better, less costly decisions. Many of our locals now provide health care plans through self-insured health and welfare trust funds. Group control allows us to spread our members' funds as far as possible by reviewing provider decisions to look for unnecessary, potentially harmful or unnecessarily expensive treatment recommendations. Because our members generally feel individually helpless to challenge a recommendation for tests or surgery, some of our locals have introduced second opinion and utilization review programs that screen providers and work with SEIU families to choose the best and lowest cost care regime.

It has taken us years of negotiating internal controls to try to eliminate cost barriers to care. One of our larger locals has used its 120,000-member fund so successfully that five years after leaving a private insurance carrier its costs are still below the premium costs of the commercial carrier. Today no insurance company would touch this SEIU trust fund for the price.

Our monitoring and control would be impossible if our members chose coverage for themselves and their families from a range of plans. We would lose our purchasing and utilization review power and with it our ability to negotiate for benefit and cost improvements on behalf of our members. Individual entitlement would simply destroy existing organized consumer leverage and cost controls. This change would affect 10 million workers (1977 figure) in labor management plans and millions more in group plans[1].

2. Loss of public control and leverage over costs and use patterns.

In the name of competition, anti-health insurance proposals would destroy the one group of organized patients most able to bargain over costs and confront providers over the costs of care: public payers. One proposal states outright that it wishes to eliminate the potential of government leverage over costs of care in criticizing:

> "The present role of government as third party payer poses a conflict of interest whereby the Government purchases or finances health care services and unilaterally determines the amount the deliverer will be paid for those services." (H.R. 850, Sec. 2, (b)(6)).

Provider protests of excessive government interference come precisely from federal and state attempts to use this leverage to contain unnecessary costs while protecting beneficiaries' access to care. With Medicare, Medicaid and other public funds currently financing some 55 percent of all hospital costs and 56 percent of nursing home costs, the potential for a strong market role is clear.[2]

A voucher system would fragment and destroy this leverage to the detriment of program beneficiaries and all health care users. Through the years these programs have moved from paying virtually all costs with no questions asked to the beginnings of controls which penalize higher cost providers. Granted, these controls are currently unwieldy and often work to hurt those facilities most reliant on public programs; yet, destruction of this purchasing power would free providers from the one consumer most able to review and compete to lower prices and costs. And in the process, Medicare and Medicaid beneficiaries would once again be put at the mercy of a private insurance system which has always shunned them as high risk, low profit consumers.

3. Fragmentation of health plans coupled with open enrollment would increase administrative and marketing costs and underwriting costs of insurers and health plans.

Again using SEIU as an example, we have virtually no marketing cost in our trust fund plans. This, plus the large size of the insured populations, allows us to keep wasteful administration and marketing costs down.

The same holds nationally. As Table 4

illustrates individual plans have a remarkably poor performance relative to group plans in benefit to premium ratios. On average, the individual plans paid out less than 54 cents in benefits for every premium dollar in contrast to 91 cents per premium dollar in the large group plans, and 98 cents in labor/management plans. Similarly, underwriting costs would increase if insurers no longer could tailor plans to particular groups. Currently, carriers of group plans can minimize the reserves required because they know the group composition. Self-selection problems would greatly increase premiums to cover larger reserve requirements.

4. Individual vouchers are likely to increase provider control and undermine any real competition by price. Taken together the cap, multiple choice and vouchers spell greater provider control over markets, not beneficial competition. Insurance companies, in competing for individual worker and Medicare/Medicaid vouchers, would be far more likely to experience rate and to avoid offering certain treatments than to confront local providers. Moreover, attempts by insurers to band together to negotiate

fees or prices would likely be in violation of anti-trust laws.

Thus the prohibition on restricted plan coverage through employer/union negotiations and elimination of public programs would remove what little countervailing power consumers now have .

Increased Access Barriers, Discrimination and Disease and Suffering

The U. S. remains the only industrialized nation of the world (except South Africa) that does not guarantee its residents financial access to care. Some 27 million Americans today have no insurance. Twelve to fourteen million medically indigent are not on Medicaid; millions more have high cost/ low benefit individual coverage.[3]

The encouragement and financial incentives to choose lower option health care coverage if "successful" would regress from past progress in slowly closing gaps in access to care. One of the major achievements of Medicare and Medicaid, in fact, has been the dramatic equalization of use of services across income groups (adjusted for health needs) following the removal of major cost barriers to care.[4] Ample studies document the unequal impact increased out-of-pocket costs will have on use of services and access to care. A $500.00 deductible simply means more to someone earning $10,000.00 a year than to someone earning $50,000.00.

The likely erosion of the financial base of inner city and public hospitals will further hurt access. If Medicare and Medicaid become voucher systems and the cost of vouchers is held down below healthcare inflation, these facilities will find themselves with rapidly dwindling revenue and nowhere to turn. State and local governments are already hard-pressed to meet health facilities budget deficits.

SEIU members in these facilities already face layoffs, wage freezes and chronic staffing shortages. Erosion of Medicare and Medicaid's current commitment to provide access to readily available services and cover reasonable costs would strike a death flow for those hospitals and nursing homes willing and committed to serve the uninsured or poorly insured. The budgets of Boston and Chicago hospitals illustated in Table 5 show how desperately such facilities need public insurance funds. Medicare and Medicaid covered 48% of Cook County's costs (1978) and 41% of Boston City's costs (1979). The vast bulk of remaining costs were uninsured subsidy costs--39% of total Cook County costs and 36% of Boston City.

In all of our cities, public hospitals are the only providers willing to treat the uninsured without question. A few nonprofit hospitals help to the extent possible. As a result, inner-city hospitals have become the primary source of care in otherwise medically underserved, high poverty areas. Some 20 million Americans live in such areas.[5] Loss of Medicare and Medicaid program commitment to pay will result in a shift in resources from low income to high income areas, exacerbating the current maldistribution.

Discrimination

Vouchers and individual purchase of health plans will segregate health care delivery into high and low insurance risks. To the extent that consumers respond to the rebate and tax incentives to choose less comprehensive care, they will be gambling on not getting sick. Those most willing to take the gamble will be the healthiest, youngest and most affluent families.

As a result, the poorer risks will suffer double discrimination. They will end up paying higher taxes and higher premiums when they seek to protect their families' greater need for health care services by purchasing more comprehensive care.

This process would quickly divide younger workers from older workers; black workers from white; workers in hazardous industries from relatively safer white collar jobs; men from women, and so forth. Even if constant government regulation and oversight succeeded in preventing health insurance companies from experience rating, adverse selection would fragment patient groups. And insurers would clearly have an incentive to game the system to market to better risk families. For example, careful choice of advertising and treatment coverage would be hard to regulate and prevent.

This process already exists in today's markets. Many SEIU locals have only been able to circumvent discrimination against our older, smaller worker groups by pooling funds and spreading risks across a much larger population. Often this process has required merger of local trust funds and multi-employer plans. This safeguard would no longer be permitted under the so-called competitive proposals and cost of care would become even more regressive than it is today.

Our people are also particularly vulnerable to unscrupulous health plan marketeering. Without careful monitoring and expert advise on the qualifications of a particular plan, we would be likely to be prime candidates for a repeat of the California Prepaid Health Plan scandal where beneficiaries enrolled in plans only to find no services available.

Health Status

The end result of access barriers and discrimination will be an increase in unnecessary suffering and perhaps even deaths. Hidden in all the furor of Medicare and Medicaid's high costs is the dramatic success story of increased low income and minority use of services and accompanying improvements in health status indicators in the past fifteen years. Infant mortality rates, virtually stable from 1955 to 1965, plummeted 48 percent from 1965 to 1979 (from 26 per 1,000 to 13 per 1,000) with no major breakthroughs in medical know-how. Similarly, chronic disease death rates improved markedly as more and more people had the financial purchasing power to use early, preventive care services.[6] A roll-back in coverage coupled with the consequent loss of resources in high poverty areas is likely to return us to our not-so-distant past when health care depended on income and wealthy families went to the doctor 20 percent more often than poorer, sicker families, pregnant women went without care, and what you earned could determine whether you lived or died.

A Regulatory Nightmare

Contrary to the proposals avowed promise of less regulation, even a casual reading of the plans reveals a regulatory nightmare for employers, unions, health insurance companies and individual consumers. To avoid extreme discrimination in the tax deductibility the cap would clearly have to be specific to narrowly defined health care market areas. The wide divergence in prices from city to city, between rural and urban areas and from state to state makes any national average irrelevant.

Employers and unions would suddenly find themselves with workers in different areas facing different tax liabilities for the same benefit packages. No amount of fine-tuning would eliminate the chaos this would create for workers and those negotiating on their behalf.

Similarly the qualification process for insurers with all its controls would impose a whole new set of federal regulations. The new paperwork per worker to determine plan coverage is awesome when compared to much simpler group plans and group premium rates.

The legal profession would be the one sure winner in this regulatory new world. Plans even detail a new "Health Court" (H.R. 850, Chapter 96) to settle plan disputes and decide actions in the event of plan bankruptcies.

In effect, rather than removing regulation these proposals merely substitute control of employer, union and consumer choices of health insurance for current regulations controlling quality and prices. The substitution is a clear loser for most of us.

Impose a Regressive and Unwieldy Change in Tax Policy

The proposed cap on tax-exempt employer paid health insurance is regressive tax policy. The cap would remove one of the few tax shelters available to people dependent on wages for their incomes while leaving untouched multi-billion dollar corporate tax loopholes.

These tax increases would come at a time when low and middle income families real incomes are declining. Moreover, the taxes would fall most heavily on families with the greatest needs for health care. These families are the most likely to purchase high-option coverage and therefore most likely to exceed the cap. Any tax that takes the most from those least able to afford to pay is clearly unfair and inequitable by any standard of tax policy.

The cap would be as unwieldy to administer as it is unfair. Employers would have to account for premiums expenditures for each employee and make some note of the age and actuarial classification of the family. IRS would then have to us regional and local cap allowances to calculate tax liabilities. Otherwise identical families for income tax purposes could now owe different taxes depending on the health needs and where they lived. The costs of the paperwork and confusion created might well exceed the additional tax revenues to the federal government with no benefit to society.

Restricted Freedom of Choice

The cap, multiple choice and voucher proposals directly restrict our current freedom to choose the providers and service plans that best meet our collective needs. Contrary to the anti-insurance proposals emphasis on the individual worker and his or her family, most of our members prefer to choose from one and maybe two carefully selected plans. Notably where some choose from a wide range of plans and financial arrangements, these members more often than not say they would prefer less "choice" and more certainty that a given plan would meet their potential health needs.

The proposals would take away this freedom to choose. No longer could we choose self-funding; no longer could we negotiate no-choice single plan coverage; no longer could we decide whether or not to press for individual choice or group coverage. Even where we have built-up a proven ability to provide our members with innovative plans at a cost below any available in the market we would be told to dissolve our arrangements.

Perhaps the advocates of such restrictions on group choice live in a world where each individual is so powerful and wealthy that he or she alone can command whatever prices and services desired. However, our members need the strength of numbers; our individual freedom comes from our working together, not alone.

Remove Essential Public Control and Guarantees of Coverage for Our Elderly and Low Income Populations

The proposal to transform Medicare and Medicaid into a voucher system is perhaps the most insidious and potentially destructive aspect of this collection of anti-insurance/ competition proposals. Where the increased tax burden on workers and interference with current business and union health care arrangements is likely to meet with strong and powerful opposition, the harm of vouchers is less readily visible and therefore potentially more salable. In light of current Administration efforts to cut budgets wherever possible while claiming to preserve basic, necessary benefits, Medicare and Medicaid vouchers with or without the full-blown anti-insurance features offer an attractive cover for reducing benefits to the elderly, disabled and poor.

Close inspection of any actuary estimates of the potential public savings from a voucher system reveal that all the savings come from a shift in the cost burden from the federal budget onto the backs of beneficiaries, not through more effective cost containment. Simply by switching to a voucher which was indexed to the rise in general prices rather than medical care expenses would shift $12 billion onto the elderly and disabled over a three year period (1983-86). This is an exhorbitant cost to impose on a population of generally low income population with severe and chronic health care needs.

It is simply false advertising to imply that most elderly, disabled or poor individuals and families could find a better plan in the private market. The avoidance of these populations was the major reason for Medicare and Medicaid in the first place and the principles of insurance have not changed in the last 15 years.

An indexed voucher would clearly erode the already fragile support Medicare and Medicaid provide for our most needy citizens. As mentioned earlier, Medicare now covers less than 50 percent of the average cost of care for the elderly and Medicaid fails to reach some 12 to 14 million impoverished families. In state after state these beneficiaries currently find a shortage of providers willing to take Medicare assignment (accept fee schedules as payment in full) or Medicaid patients due to public program attempts to curtail expenses.

Vouchers would destroy even this protection for these individuals with the greatest health problems. If coupled with a rebate, relatively healthier families might be lured to withdrawal acceptance of a voucher to purchase to private coverage. This would leave the sickest, frailest families in the public program with even less leverage to purchase care. The adverse selection could easily lead to higher rather than lower public costs _if_ public officials maintained a commitment to covering necessary costs of care.

Our retired members desperately need this commitment. A recent SEIU brochure explaining the gaps in Medicare and what to look for in private supplemental coverage was an instant sell-out. Our pensions plus Social Security are too meager to risk the already high deductible (nearly $300,000 combining Part A and B following recent amendments), 20% medical cost-sharing hospital co-payments, and other coverage restrictions. Few younger families would buy such a plan. We need more not less coverage.

As mentioned earlier, vouchers would also sacrifice the most vulnerable health institutions. Our members who work in these inner-city and public facilities can all testify that they are providing care of the last resort. Vouchers which save federal and state budget dollars will translate directly into increased bad debts in facilities on the brink of bankruptcy. Yet nowhere in any proposals to date do we see plans to pick up this debt to protect low income communities and essential jobs. We would be glad to supply the committee with extensive documentation that this imminent destruction is real. Given that the driving force behind vouchers is the wish to shift the federal budget burden elsewhere, we see this policy as thinly disguised return to survival of the fittest at its most vengeful.

Summary

We have touched briefly on fundamentally distorted theory behind anti-insurance/competition proposals and the adverse impacts on costs and care flowing from so-called market reforms.

Our staff is available for any further information or documentation of points raised in this testimony.

Again, on behalf of our President, John Sweeney, and all of SEIU, we thank the committee for holding these hearings. We hope discussions today will open up broad public awareness and understanding of the destructive content behind the competition's choice labels.

TABLE 1

Medical Price Inflation Has Exceeded General Inflation Regardless of the Extent of Third Party Coverage

1950 - 1979

	Expenses % Covered by Third Party	Annual Percent Change		Medical Price Increase as % CPI
		CPI	Medical Prices	
1950-55	65.5% (1950) 58.1% (1955)	2.2	3.8	172.7%
1955-60	54.9% (1960)	2.0	4.1	205.0
1960-65	51.6% (1965)	1.3	2.5	192.3
1965-70	40.0% (1970)	4.2	6.1	145.2
1970-75	32.4% (1975)	6.7	6.9	103.0
1975-79	31.8% (1979)	7.9	9.2	116.5

Source: U.S. Department of Health and Human Services, Health United States, 1980, Tables 62 & 67, December 1980.

TABLE 2

Percentage Distribution of Health Care Expenditures by Channels of Payment for Hospital Care, Physicians' Services and All Other Health Care Services, Calendar Year 1977

Age Group	Total	Private				Public			
		Total	Direct Payments	Private Health Insurance	Other	Total	Medicare	Medicaid	Other
All Personal Health Care									
All Ages	100.0	61.0	31.8	27.9	1.3	39.0	14.6	11.2	13.2
Under 19	100.0	71.5	38.1	32.7	.7	28.5	.1	15.6	12.8
19-64	100.0	71.2	31.9	37.4	1.9	28.8	3.0	8.9	16.9
65 and Over	100.0	36.1	29.1	6.6	.4	63.9	44.2	13.8	5.9
Hospital Care									
All Ages	100.0	45.6	8.3	36.2	1.1	54.4	23.9	9.5	21.0
Under 19	100.0	54.6	3.7	50.7	.2	45.4	—	25.0	20.4
19-64	100.0	59.2	10.7	46.9	1.6	40.8	4.9	9.6	26.3
65 and Over	100.0	12.0	4.6	7.1	.3	88.0	74.7	3.9	9.4
Physician Care									
All Ages	100.0	74.1	33.9	40.1	.1	25.9	14.7	6.0	5.2
Under 19	100.0	84.4	38.7	45.7	—	15.6	.4	12.1	3.1
19-64	100.0	84.5	35.7	48.6	.1	15.5	2.4	5.6	7.5
65 and Over	100.0	41.8	26.2	15.5	--	58.2	54.2	3.1	.9
All Other Care									
All Ages	100.0	73.9	62.5	9.0	2.4	26.1	1.9	16.7	7.5
Under 19	100.0	78.5	70.2	6.9	1.5	21.5	—	9.2	12.3
19-64	100.0	81.2	63.4	14.0	3.8	18.8	.2	10.2	8.4
65 and Over	100.0	60.6	58.0	1.9	.7	39.4	5.3	29.9	4.2

Source: Charles R. Fisher, Difference by Age Groups in Health Care Spending, Health Care Financing Review, Spring 1980.

TABLE 3

Distribution of Medicare Hospital Costs for the Aged Population, 1978

Average = $636.00

$ Reimbursed per Person	People (thousands)	% All Enrollees
$ 0	9,520.0	39.7%
0 - 499	8,823.0	36.8%
500 - 999	1,200.5	5.0%
1,000 - 1,999	1,460.9	6.1%
2,000 - 2,999	853.4	3.6%
3,000 -	2,111.7	8.8%

Source: Health Care Financing Administration, Medicare Program Statistics

TABLE 4

Financial Experience of Individual Versus Group Health Plans

1977

Type of Plan	Premium Income $ Billions	Claims as % Premium
Total	$47.1 B	88.3%
Blue Cross/Blue Shield	19.6	90.1%
Insurance Companies	23.0	85.0%
Group	19.4	90.8%
Individual	3.6	53.7%
Labor Management	2.7	98.7%
Consumer	1.4	95.2%
Other Independent Plans	.5	89.0%

Source: Marjorie Smith Carroll & Ross H. Arnett III, "Private Health Insurance Plans in 1977; Coverage Enrollment and Financial Experience," Health Care Financing Review, Fall 1979.

TABLE 5

Inner City Hospitals Depend
on Medicare/Medicaid for Survival

	(1978) Cook County, Chicago	(1979) Boston City
Total Patient Days	380,786	133,519
Total Cost	$102.5 million	$81.2 million
% Private Insurance	12.4%	8.6%
% Medicare	13.6%	19.6%
% Medicaid	34.1%	21.8%
% Self Pay	.4%	13.8%
% Bad Debt/Subsidy	39.4%	36.1%

Source: Cook County, Hospital Department of Finance.

Boston City, Estimated from Massachusetts Rate Setting Report and Medicare Cost Report, 1979.

SOURCE NOTES

1. Marjorie Smith Carroll and Ross H. Arnett III, "Private Health Insurance Plans in 1977: Coverage Enrollment and Financial Experience," Health Care Financing Review, Fall 1979.
2. Robert Gibson, "National Health Expenditures, 1979," Health Care Financing Review, Summer 1980.
3. Karen Davis, Reagan Administration Health Policy, Paper Processed John Hopkins University, August 1981.
4. Karen Davis and Cathy Schoen, Health and the War on Poverty: A Ten Year Appraisal, Brookings Institution, 1978.
5. Karen Davis, Op Cit, August 1981.
6. Karen Davis, Medicaid and Health Care of the Poor, Testimony before the U.S. Congress, Committee on Energy and Commerce, Subcommittee on Oversight and Investigations and Subcommittee on Health and the Environment, July 27, 1981.

[The following was subsequently received:]

STATEMENT OF THE FOOD & BEVERAGE TRADES DEPARTMENT, AFL-CIO

The Food and Beverage Trades Department represents over three million workers in the food and allied service trades. Affiliated members work at some of the lowest paying jobs in the country. These workers, over the course of the years, have bargained with management for medical care policies that will ensure their families' continued health. In many instances, workers have sacrificed pay raises, better pension plans, more vacation time, etc., in order that the health care package be adequate for their families. To enact legislation such as H.R. 850 would not only deprive workers of the right to comprehensive health care, a right provided for in almost every other industrialized country in the world, it would negate many years of collective bargaining.

H.R. 850 is based on the false assumption that consumers decide on medical care according to the amount of insurance coverage they have. In truth, doctors are the decision-makers. They decide whether patients should undergo tests, receive outpatient care, or enter a hospital. They attend years of medical school and serve several interships before they are considered qualified to recommend appropriate remedites. How, then, can proponents of this legislation expect a layman to make the critical decision of whether or not he needs the care prescribed by his physican? Yet, H.R. 850 assumed that if consumers have less comprehensive insurance, they will choose not to seek medical attention as often. Furthermore, statistics show that long before medical insurance became prevalent, consumers sought the medical attention their doctors advised even if it meant incurring debts.

Besides avoiding the real causes for soaring medical costs, H.R. 850 would shift more of the tax burden onto low- and middle-income families who can little afford it. Many Food and Beverage Trades Department (FBTD) members who fall into this category would pay taxes on an additional $1200 per year that would be considered taxable income under H.R. 850. In one FBTD local alone in the Baltimore/Washington area, this would affect 10,000 workers. It would mean that any tax breaks these people would receive from recently enacted legislation would be reduced significantly. A study by the AFL-CIO's Social Security Department shows that a family of four with one wage earner earning the medium income of $21,000 will pay $114 in additional taxes per year to maintain his/her current level of insurance. This is one-half the meager amount an average family in this income group expects to receive under the Reagan Administration's tax cuts.

H.R. 850 also assumes that if a ceiling is placed on the amount employers contribute to employee health plans, workers will "shop around" for the best coverage for their money. In turn, insurers would be more likely to compete for business. It does not make sense to assume this situation does not exist already. Regardless of the amount of money available, consumers opt for the insurance company that provided the best health care package for their dollars.

In summation, the "National Health Care Reform Act" would not remedy the current dilemma of soaring medical costs. Rather, it would lower the standard of health care many workers have finally been able to achieve. Only if legislation is enacted that contains hospital and physicans' fees can we expect to slow the ever upward spiraling cost of medical care and, at the same time, guarantee a suitable degree of health care for workers.

Mr. **McGlotten.** Obviously you can see by the expression of the four of us sitting here we are opposed to these bills. Clearly 3 years ago we had a bill on the floor that tried to deal with the question of hospital costs and hospital cost containment. That bill lost. The voluntary program obviously it not working.

I think it is important for us to understand that to deal with the question of medical costs you must go to the industry itself and not put consumers who are looking for the kind of care that insures that they are healthy individuals—that they are able to come to work on a day-to-day basis, that employers are happy with their performance, and say to them they must now remove themselves from proper health care plans, I think is highly irregular.

I think also it is very, very bad policy to try to take the revenue act of our society and try to construct social justice as far as the health care.

Chairman JACOBS. Thank you for your testimonies.

Mr. Rangel?

Mr. RANGEL. Thank you, Mr. Chairman.

In my neighborhood, some people say that every time Rangel joins a club, they change the rules.

The last time I saw this group together, I was chairman of the Health Subcommittee. At that time you were telling me that I should support the Kennedy bill, and not President Carter's bill, and the Corman-Carter bill. I didn't hear any testimony today about that on the Dellums national health system bill. Now we are dealing with the free marketplace concepts.

I just wondered whether the change in the chairmanship brought this new thrust about?

Mr. SEIDMAN. Mr. Chairman, it was not the change in the chairmanship but the fact that we understood that the hearing was on a particular concept is being proposed, and we tried to address ourselves to that.

However, I want to assure the members of the subcommittee that the labor movement, the AFL-CIO, and I am sure I can speak for the other members of the panel, feels just as strongly as we did last year that the best way of achieving what I think we are all after, which is quality health care for people at a cost they can afford, is through a system of universal and comprehensive national health insurance.

We have not in any way pulled back from that position. We do not know that is under any serious consideration at the present time. We are realists. We are addressing ourselves to what we think is the very grave danger in the approach which is being suggested now.

I believe Mr. Glasser wants to supplement what I have said.

Mr. GLASSER. I would simply supplement it in one simple way, Mr. Rangel. The limitations of time prevented me from alluding to page 7 of my testimony where I have spelled out our commitment to the right kind of national health insurance, which your constituents and the whole country need, in our judgment.

Mr. RANGEL. Tell me, since you studied the competition bills, in any of these bills—I know Ms. Schoen referred to it—do they give us any direction as to how the people who have no coverage now and for whom this committee and the Congress have long been concerned obtain adequate coverage. If they are unemployed, poor, and aged, and they have no coverage at all, or if they are working and are not covered by unions and not covered by medicaid or medicare, how do they fit into this free market scheme?

Mr. SEIDMAN. Those who are the proponents of these bills have said that they are not intended in any way to provide coverage for people who do not now have it or to provide decent coverage for people who now have minimal coverage.

They are not—they do not—they are not put forth as a substitute, for example, for national health insurance, which would try to achieve those goals. But actually, we are very much concerned, because we think that the bills would result in worse coverage, worse health care for the most disadvantaged people because of the fact that new costs would be piled onto the institutions like the public hospital, the inner city hospitals generally. There would be an incentive for the other hospitals, even a greater incentive than now, to force these people into those hospitals and there is nothing in these bills which would do anything at all along the lines which you suggested, Mr. Rangel, last year, and perhaps you are advancing again to help these inner city hospitals.

Mr. RANGEL. Tell me: What happens if a person who has union coverage and is faced with getting a rebate or trying to get maximum coverage for the least amount of money projects the future health needs of his wife and three kids and makes a mistake?

Mr. SEIDMAN. It is a game of Russian roulette. You bet on the possibility that you are not going to be—or a member of your family is not going to be gravely ill, is not going to be hospitalized, is not going to need surgery. The low cost plan will contain many exclusions. It will have very high deductibles, very high company insurance. The people who will choose because of the financial and economic pressures on them, the people who are most likely to choose those plans are, first of all, people who can be expected to be healthy and maybe most of them will, but some of them may guess wrong, too.

Second, low income people, who see the immediate advantage of a tax exempt rebate, which is cash in the pocket, they will bet the health of themselves and their family, under that severe pressure—they wouldn't do it otherwise and choose the low cost plan. Then if the illness does occur, they do need the hospitalization, if they do need the high cost surgery, they are going to have to turn to the public hospitals or other inner city hospitals and those hospitals will have no additional income to take care of them and so we will face a very, very serious situation, even more serious than the situation that we face now which is extremely critical.

Mr. RANGEL. Thank you.

Thank you, Mr. Chairman.

Mr. GLASSER. May I amplify that with one figure, Mr. Rangel, it just happened over the weekend I was with an administrator of the Cook County Hospital of Illinois which as you know is a very large public hospital. In July the new rules in the State of Illinois on medicaid went into effect, reducing eligibility. That is not the new federally enacted rules. In the first 2 months, facing lower income, the hospital had 200 additional outpatient visits a day over the same period a year earlier; and that was before the full impact of the new Federal cutbacks took place. Two hundred a day. What they are now facing, is, where will they get the money to handle these people even if they had the space?

Ms. SCHOEN. Picking up on Cook County, on table 5 of our testimony, Cook County is one of our hospitals. They had 39 percent of all costs in bad debts, self-pay patients who had to be publicly subsidized beyond medicaid before this cutback. That is where people are going to be going.

Chairman JACOBS. Mr. Gephardt.

Mr. GEPHARDT. Thank you, Mr. Chairman.

I appreciate your appearance here and your testimony very much. The point we just made in the last exchange that these bills really harm the poor and that there is no protection for catastrophic costs and that the people that are not now in the system or left out of the system. I am sure you are all aware, though, in the bill I worked on there is a catastrophic feature, expenses above $2,900 have to be covered in any plan.

Mr. **Seidman**. $2,900 is an awful lot of money for a low-income family, Mr. Gephardt.

Mr. **Gephardt**. You understand the plan does more than cover $2,900. We are talking about catastrophic coverage. Indeed, any plan that qualifies for any tax exclusion under the bill has to as a floor, as a minimum, over that in addition to what else it can offer to attract consumer dollars.

Second, the bill brings medicaid coverage to a national standard rather than the State standards that now exist; and third, that it does offer a tax credit for people who are not now in the health care system, whose employers give them no benefits. So, I hope you would agree that at least the bill does attempt, perhaps more than other bills, to deal with the very real problems that exist for people that fall through the cracks of coverage today that have been always a concern of groups like yours and groups that have been interested in national health insurance.

My question today really goes to this whole business of how we attack the problem that I think we share a view on.

You all said that there are cost problems that need to be addressed; there are coverage problems, quality problems. Mr. Seidman, I think you gave an eloquent statement of what you see as the root cause of the problem, and that is that physicians are in control of the system and that, as providers, they perhaps have not been as cost conscious as they could have been.

I guess the question becomes how do we, as a society, best make that group and providers in general more conscious, more concerned about efficiency?

You stated that the volunteer system hasn't seemed to have worked. You did say you were for the mandatory system that President Carter proposed last year. I guess my question is do you believe that things like cost containment or national health insurance are really going to better attack both the costs and the quality problems? I would like you to tell me if you believe that and if you do, why?

Mr. **Seidman**. Yes, sir, we certainly do. Of course, we came before this committee in other years with lengthy statements explaining our position on this; but if you are looking particularly at the cost question, to a limited extent, the hospital cost containment bill—to a much greater extent the national health insurance proposals—and there have been a series of them that we have supported over the years—have provided effective cost controls and incentives for cost restraint.

In the first place, they provide for a national budget for health care expenditures. There is nothing in these bills that does anything along these lines.

Second, they provide for something that—about which there is really very little—very little difference of opinion any more. That is prenegotiated budgets of institutional providers. They provide incentives and we think these bills provide disincentives for the development and expansion of HMO's, and even for physicians under other circumstances to come—under capitation systems, which we think are far more cost-effective, and most people do. We are not alone in that idea anymore. We used to be but we are not any more.

The capitation approach provides the cost incentive that the fee for services system does not. If we look across the border to Canada, we see all of that happening.

Mr. GEPHARDT. Do you see costs coming down in Canada or anywhere?

Mr. SEIDMAN. Costs are not coming down anywhere in the world, Mr. Gephardt. The costs of medical care in Canada as a percentage of GNP have been 7 percent over a period of approximately 10 years now; stable as a percentage of GNP. That means medical care costs have not been going up any faster than other costs and that hasn't been true in any year in the United States during the past 10 years, and we see no reasoning to think that it will happen if these bills are enacted.

Mr. GEPHARDT. How did they achieve that in Canada? They did that by cost containment? Is that the process they used?

Mr. SEIDMAN. They do it first of all by establishing a budget for health care expenditures. They do it, second, by negotiating with the hospitals in advance of the—their expenditures. They do this by negotiating with the physicians. The one thing they haven't done—and I think that they would have achieved more cost containment if they had—is to provide more encouragement for the development of what we in this country call HMO's. I think many Canadians regret this, but this is one thing that they have not done.

Despite that, despite the fact that they have not had any expansion of HMO's, they have been able to restrain the increase in health care costs.

Mr. GEPHARDT. Can I ask a question of Mel Glasser? You made a point, I think, that one of the problems you see here is that by taking the union and the employer out of the process, that we would harm health care, because we would harm the negotiation, the competition that has come through the negotiation that has gone on.

Would you be more favorable to some of the competition proposals if we did not cause the individual to make a choice but left that choice to unions and/or employers?

Mr. GLASSER. I think the answer to that would have to be no. It would be a preferable way of doing it, but it is only one of a dozen major objections; primarily objections to the concept, the theory, the approach that the union movement has. Yes, I think it would be preferable certainly to keep the employer and the union in the picture, but that would not make the competition proposals of such a nature that I think unions could support them.

Mr. GEPHARDT. Thank you very much.

Chairman JACOBS. Mr. Gradison.

Mr. GRADISON. Thank you, Mr. Chairman.

I would welcome any comments which anyone on the panel might have in connection with the bill H.R. 3399, which has passed the Energy and Commerce Committee which would allow HMO's to be reimbursed at 95 percent of the average cost of providing services to medicare beneficiaries; and more broadly, I would like to know what you think about a voluntary option granted to medicare beneficiaries in a voucher form.

Mr. **Seidman**. These are two separate questions.

Mr. **Gradison**. Yes, I understand that. I seperated them in the way I asked the question.

Mr. **Seidman**. Let me comment on the first question and then the second as far as the bill which has passed the House subcommittee, we are strongly in favor of that. We have been in favor of it for a long time. In essence, what it does to permit HMO's to function and operate under the medicare program in ways which permit the HMO to achieve for their medicare members what they seek to achieve for all their other members, which is higher quality cost—higher quality care at lower costs. By shifting essentially to a capitation approach, which is what is involved in this, it seems to me this is highly desirable.

Mr. **Gradison**. It also broadens, as I recall, the definition of an HMO beyond that under present law?

Mr. **Seidman**. Perhaps you would like to comment on that.

Ms. **Schoen**. It loosens some of the requirements, yes.

Mr. **Gradison**. You are supportive of that?

Mr. **Seidman**. We are generally in support of the approach. We do not want to see the repetition of the experience that California had with so-called prepaid plans that turned out to exploit the poor and the elderly, and we would not want to see the definition broadened to such an extent that that would be possible.

By and large, we do not favor the development of plans which are confined to the elderly or confined to the poor or largely confined to the poor and elderly. We want to see the HMO movement develop as it has in the past with—and with even more of the elderly and poor, but not with the elderly and poor the predominant portion of their membership.

As far as the voucher system is concerned, we think that the voucher system is one which has—in the first place—it is not going to reduce costs unless it reduces services. It is a very inefficient way, it seems to us, in terms of cost-effectiveness providing medical care for the people who are covered by medicare and it would be even more true of medicaid.

When the insurance companies sell on an individual basis, you have all of the costs involved, marketing, promotion, and administration which are now minimal in the medicare program, and as our testimony has indicated, perhaps one-fourth as much as it is in private insurance.

So that we would not be in favor of this approach.

Second, it is our understanding that the purpose is to keep the vouchers low and they would gradually provide fewer and fewer services for the people involved, and this we would be strongly opposed to.

If the costs were to be the same--if you kept it as a system where you had the vouchers side by side with the medicare program, and the rest of the medicare progam as it has been, and the costs were the same and not higher for the private part of it, then that means that the people who went into the private part would be getting fewer services.

Now, this would be—because the costs would be higher, as I have already indicated.

Mr. **Gradison**. Could I interrupt to just ask a question because you lost me about three paragraphs ago.

You said you liked the idea with regard to HMO's. Then when it comes to making this voucher idea available for dealing with other groups which might be formed—they might be groups of doctors, hospitals, insurance companies, or whoever—you said it won't reduce costs unless it reduces services. Now, my understanding certainly as a supporter of the voucher concept in medicare is that before any package could be offered, it would have to at least provide the full benefits available under the present medicare program.

In other words, to sell one of these, any group offering it would have to offer more or they wouldn't even be permitted to offer them in exchange for the voucher. That would be a written-in requirement.

I am a little confused as to why you extol the virtues of the HMO, presumably feeling that they are not going to cut services even though they are only getting 95 percent on the dollar under that bill that you just supported, but if we extend this more broadly, you are assuming that services would have to be cut. Why?

Mr. **Seidman**. I am assuming services would have to be cut because I am assuming the costs would be higher whereas in the case of the HMO's, the costs are actually lower.

Second, it is my understanding that the same amount of money would be paid per capita. That doesn't mean that the same services would be available, and even if the bill were to provide that the same services had to be made available, I question very much where this would be policed in a way which would assure that the individual, elderly, and poor people who would be covered by this program would actually get the same kind of services.

Mr. **Glasser**. Mr. Gradison, key to this issue is standards. You raised it quite properly when you raised the initial question. That is you said you would loosen the standards on HMO's in your dual choice bill on medicare, which is something the labor movement supports, but only with standards. Anybody who——

Mr. **Gradison**. Excuse me. I am not talking about quality of care when I say standards. I am talking about the definition of a group. I really don't care whether a group that comes in and offers this voucher meets the technical definition of an HMO today or whether it is a hospital or a group of doctors or an insurance company, so I am looking at the package of services that they offer. Please don't twist the words. I don't think you intended to, but I don't want to leave any question about this. When I talk about standards, I am only talking about the definition of an HMO. The medicare voucher system I am supporting, and I think we will be hearing more about in the months ahead, could only be offered if the Secretary found that the package of benefits at least those services covered under the current medicare system.

Mr. **Glasser**. Mr. Gradison, what I am trying to do is not in any way twist what you are saying but establish a differentiation in the definition of standards. We in the labor movement believe that part of standards are not only benefits but how they are offered and how they are delivered. That is a big difference.

Half the people—let's go to the voucher question—half the people who are past the age of 65—I will restrict this analogy—do not have a chronic illness; roughly half do have.

In essence what the voucher says is if a man or woman is unlucky enough to have a chronic illness, and the price of the voucher is priced at the average of costs in any given year, and his expenses indeed will go far beyond that, he will either pay it out of pocket or the private insurance fund, if he is in it, will go broke. This is a fundamental contradiction in this that to my knowledge no actuary, no health insurance expert has ever come up with any kind of approach that makes sense. If all the people with chronic illness go one way or the other, whichever choice they make, whether they stay with medicare or select a private insurance industry plan, the voucher system will break one plan or the other.

Mr. **Gradison**. Why hasn't that happened under the present situation in which there are some medicare beneficiaries receiving the services from HMO's?

Mr. **Glasser**. Because the number is very small. They are receiving them from plans which have, as you know, substantially lower costs because of their ability to control costs in the HMO system. This is not part of the voucher system; and because at this point, we are not having adverse selection simply because the numbers don't mean much. For example, I have been associated with a plan which has had 4,000 out of 75,000 medicare beneficiaries as members all along, without capitation, on a fee for service basis. They have not been a loss group to us. If you look at them, they happen to be people who like this kind of program.

Mr. **Gradison**. Thank you.

Chairman **Jacobs**. I would just direct this comment to the panel for your observations. Some reference has been made to the tax changes advocated by this legislation, the tax deduction, and the Federal income tax changes. There is a tax increase, which in some instances would have cut in half the tax cut, the so-called tax cut, that was given to a great number of people in the recent legislation. As I see the situation, a very significant, or a large majority of the American taxpayers got no tax cut at all if you take into account the requisit interest rate increase from the Government borrowing to finance the tax cut. I suppose everybody knows by now it was not an across-the-board tax cut at all, but a very significantly higher percentage for the very well off than was the case for the not so well off and the very poor.

My guess is that when the legislation was first drafted, the thought of its being a tax increase was not present. It was merely thought of as the incentive or the competitive idea. I would just ask for elaboration from the panel on that aspect of the situation where, as I see it, a majority of the American people have suffered a tax increase if you consider the higher interest rates that that category of person has to face in buying a home or an automobile.

I guess those making $200,000 and above who collect that interest don't pay it when the others have to go out and buy things. I only heard one comment about it, but is that a significant matter to labor, the question just of the tax increase or decrease?

Mr. **Seidman**. Mr. Chairman, it certainly is. What you are saying only emphasizes the point that we are making, that workers who have gotten very little or—depending upon how you look at it—nothing out of the tax cut would find themselves faced with a choice of higher taxes or less health care. So they have been discriminated against first in the tax bill and then they would be discriminated against again if this legislation were to be enacted.

Chairman **Jacobs**. Ms. Schoen, Mr. McGlotten, Mr. Glasser?

Ms. **Schoen**. Not only that, but it discriminates against the sicker worker as well. If you find yourelf with chronic health care conditions you have two choices under the bill, you can either buy very comprehensive health care, in which case you would be paying higher taxes because you would be exceeding whatever the cap existed. There is no way actuarily you can fine tune for every individual family on their health care needs. Or you would choose a lower option plan and have very high out of pocket costs. In either way you are shifting costs to the sickest families as well as those who might be able to get fairly comprehensive care. It is a very regressive way of using tax policy in terms of where tax loopholes generally are right now. There aren't very many tax exempt deductions for workers if you consider the total pie of tax deductions.

Mr. **Glasser**. May I say two things in relation to that, Mr. Chairman. This is alluded to on page 7 of my testimony, the delineation of the issues that you raise.

The two things I would say are that when you have a flat premium system, as you do in American private health insurance, or as you would under a low option/high option plan, you would start with the regressive situation wherein a worker who is paying $120 a month out of a $10,000 salary obviously is paying a great deal more of his income than someone who is paying out of a $50,000 salary.

That gets exacerbated by this tax cap situation where, indeed, you have a double whammy on the low income worker. The double whammy is when he or she is offered the choice of enough money to buy food and housing as against the opportunity to get health insurance, he is likely, particularly if he is younger, to gamble, to gamble away the health insurance and take the cash.

Second, he is paying disproportionately more of his income. Now there has been a lot of discussion here about guesses of what would happen. We have lots of experience to indicate that with both workers and employers, there is a wish for comprehensive benefits and for higher options in plans, even when it has meant payment out of pocket. As you know among the Federal employees, 90 percent of them choose the high option plan which costs them in a major way more than the low option. The irony of this is that half of these employees who choose high option have employed spouses, so that, in fact, they may be buying high option benefits they don't need, but they buy it because they need the security of protection.

When we have polled our members in the U.A.W. and asked them for priorities they have—until the recent recession, when jobs were first—always put improved health care protection as No. 1 of where they want to spend their collective bargaining money, as against pensions, as against supplementary benefits, et cetera.

May I also call to the attention of the committee the research reported about 3 months ago, from MIT's health research group reporting for the National Center of Health Services Research, that when they polled the chief executive officers of 69 major corporations and talked with them, with personnel officers, et cetera, overwhelmingly the firms said they were prepared to provide comprehensive health benefits for their employees, they were reluctant if not unwilling, to consider reduction in coverage and lesser benefits because they were important factors in productivity, in employee satisfaction, and in continuity of employment of workers they ended.

These are the opinions of chief executive officers of companies which are largely paying for these benefits.

Therefore, I say to the committee, we have both labor and business saying this less insurance approach is the wrong direction, and I am puzzled why we are considering it this seriously.

Chairman JACOBS. That is an excellent note to conclude this panel on. We are considering it because it was a proposal made by some thoughtful members and the hearings are for the purpose of generating support or opposition; but above all, we would hope for the purpose of enlightenment. I believe this panel has contributed significantly to that situation.

Mr. SEIDMAN. Thank you.

Mr. MCGLOTTEN. Thank you.

Chairman JACOBS. The next panel is made up of the American Hospital Association, John McMahon, president, accompanied by Allen J. Manzano, senior vice president of the Washington office; the Federation of American Hospitals, Michael Bromberg, executive director; National Council of Community Hospitals, John Hoff, general counsel.

Gentlemen, follow the rules of the New York State Athletics Commission. Proceed.

STATEMENT OF JOHN ALEXANDER McMAHON, PRESIDENT, AMERICAN HOSPITAL ASSOCIATION, ACCOMPANIED BY ALLEN J. MANZANO, SENIOR VICE PRESIDENT AND DIRECTOR, WASHINGTON OFFICE

Mr. MCMAHON. Mr. Chairman and members of the committee, I am Alex McMahon, president of the American Hospital Association and I appreciate the opportunity to appear before you again on a very key issue. You have my testimony. I would be glad to answer any questions on the details. I would like to confine my remarks this morning, Mr. Chairman, to a few broad points. The first point is I think we need to change the incentives in our health care system. Alice Rivlin made the point, I would like to reinforce it: The tax subsidy for health insurance and cost reimbursement under medicare are all expansionist incentives. They encourage the development of more health care opportunities. They encourage the utilization of it. I think all those things were put in place, Mr. Chairman, to expand the health care system, giving us a message to provide more and better care for people. What has happened, however, is that we now have a cost problem. In providing more and better care for more and more people we have run into a very deep cost problem. It is a problem we are suffering in terms of voluntary effort today because we are trying to encourage voluntary cost containment when all the incentives in the system run to expansion.

The second point, Mr. Chairman, members of the committee, is the American Hospital Association believes that consumer choice, as we prefer to call it, can change incentives both among the employed population and among the medicare beneficiaries.

That choice, the exercise of a choice, will lead to cost consciousness on the part of patients. That perhaps in turn will lead to cost consciousness on the part of providers. I do not understand the competition issue, Mr. Chairman, so much because we have plenty of competition in the health care world today. We will have more and more and more as physicians are trained and go into practice.

On pages 4 and 5 of my testimony I have set forth the position of the American Hospital Association with respect to the employed population. Our belief is that consumer choice can be reinforced by a tax limit on the employer contribution, by equal contribution and a reward for a price conscious choice, and third by a mandatory choice.

I was impressed as I listened to the purpose of these hearings, as you pointed out a few minutes ago, Mr. Chairman, I was impressed by Clark Havinghurst having comments that perhaps mandating choices leads to more regulation and more problems. Certainly that ought to be explored.

We also pay our respects to the idea of voucher or a choice to be exercised in the medicare program. We think, as Paul Ellwood pointed out, that is a good place to begin, because it can provide a politically feasible opening up of choices, but a choice, Mr. Chairman, that is designed to bring about a cost consciousness.

I think it has been overlooked in the testimony this morning that what we are talking about in the medicare program has particular effect to those 50 percent of the beneficiaries who have added their own supplemental program. It is in the combining of the medicare program and the tax—the supplemental insurance itself—that an opportunity for price conscious behavior on the part of both beneficiaries and providers can come about.

Two final points, Mr. Chairman: I trust this committee will put some faith in the marketplace. Innovation still abides in America, and it abides in the medical care system. And with choice, I think you can expect to see responsive and price conscious reaction with the change in incentives. I hope, too, the committee will adopt a principle of minimizing the regulation that goes along with the exercise of that choice, because the more regulation there is, the more complications there may be.

May I conclude, Mr. Chairman, by urging the subcommittee to resist the doleful predictions of economists. They don't have such a good record of predicting how people will respond to different kinds of systems. I would point out, too, that much of the opposition to consumer choice derives from unwarranted assumptions to foregone conclusions matching resistance to change and the fear of the unknown. We must change the incentives, Mr. Chairman, and consumer choice is a good place to start. We stand ready to help the subcommittee and its staff on any of the details.

[The prepared statement follows:]

Statement of the American Hospital Association

Mr. Chairman, I am John Alexander McMahon, President of the American Hospital Association. With me is Allen J. Manzano, Senior Vice President of the AHA and Director of the Association's Washington office. Our Association represents more than 6,100 member hospitals and other health care institutions, as well as over 30,000 personal members.

We appreciate this opportunity to present our views on consumer choice approaches to financing health care and commend this Subcommittee for its continued attention to the issues of health insurance and health care costs. In this discussion of health care economics and financing, I would emphasize that we should not lose sight of our ultimate interest in maintaining the ability of our nation's health care system to deliver high quality services to patients who need them.

Since we last testified before this Subcommittee on proposals to reform health care financing, the political interest in marketplace alternatives to government regulation has increased greatly. The Reagan Administration has made a strong commitment to reform of federal regulatory structures and to the stimulation of private sector involvement in economic problem-solving. As part of this effort, the Administration has proposed a reduction of federal regulation in a number of areas, including health care, tax reform and, in general, a lessening of the federal role in state, local, and private activity. In addition to such proposals, the Administration remains concerned about issues of cost and utilization in health care, with their direct and indirect consequences for the federal budget.

As a result of new federal policy, greater interest in consumer choice approaches to health care financing has been stimulated in the public and private sectors. Both the Senate and the House of Representatives have before them legislative proposals designed to restructure the economic incentives of the health care marketplace. And the Administration has made clear its commitment to the development of a major consumer choice proposal by early next year. Therefore, it is most appropriate that we continue discussions of consumer choice concepts in this forum.

AN OVERALL VIEW

The American Hospital Association continues to believe that consumer choice approaches to health care financing, aimed at increasing the involvement of consumers in the economic consequences of choosing health insurance and health care services, represent a promising alternative to traditional regulatory approaches. Consumer choice concepts are intended to moderate health service demand through increased consumer awareness and to place more of the decision in the hands of the American public as to how much of the nation's resources will be devoted to health care. Recognizing that or society no longer can afford to stimulate the demand for health services indefinitely is a significant step toward controlling costs in a manner consistent with the efficient delivery of needed health services.

The AHA recognizes that changes in the current financing and payment system could create new and different risks for hospitals and other providers of health care services. Nonetheless, we feel that many of these concerns are fears of the unknown. Therefore, the AHA has taken an active role in stimulating discussion and examination of consumer choice concepts.

AHA staff have developed discussion papers analyzing various aspects of these concepts and disseminated them to state and local hospital associations, hospital administrators, and others in the health field. Building on this staff work, AHA sponsored a series of regional meetings earlier this year to bring together representatives of hospital management, the medical community, health insurers, health maintenance organizations, and the business community to identify and respond to major issues. We are not yet satisfied that all, or even most, of these issues have been resolved. Nonetheless, the Association's House of Delegates, our policy making body representing hospitals in the 50 states, has endorsed major aspects of the consumer choice concept. We anticipate that hospitals will continue to be actively involved in the development and resolution of the consumer choice debate.

SPECIFIC COMMENTS

The current health financing and insurance system is multifaceted, composed of the privately insured (the majority of whom are insured through the employment setting), those insured through public programs (primarily Medicare and Medicaid), and the uninsured. The character of the system requires that evaluation of consumer choice proposals consider the component groups separately.

For purposes of discussion, AHA defines consumer choice approaches to be those proposals, legislative or other, that would (1) increase the number of health benefit plan choices available to the financially-involved consumer, and (2) increase the financial involvement of consumers in the purchase of health insurance benefits and of individual services.

Employed population

The majority of legislative proposals introduced to date focus on incentives for the employed population, the single largest insured group in the country. The AHA House of Delegates has identified and endorsed three basic principles of meeting consumer choice objectives for this population:

A limitation on the tax-free status of employer contributions to employee insurance plans;

A fixed and equal contribution by the employer to all employees; and,

Mandatory choice of plan.

The AHA recommends that these principles guide the Subcommittee in its consideration of any consumer choice legislation.

We note that several design questions have arisen from specific proposals to implement consumer choice principles. Primarily, these focus on the identification of appropriate mechanisms to control potential underinsurance and adverse selection tendencies among the employed population.

Underinsurance.—A basic policy issue is the extent to which, in a consumer choice environment, employees should be protected from certain major risks associated with selection of inadequate or inappropriate insurance coverage, given that solutions to the problem of underinsurance could entail greater regulation of, and administrative costs for, employers and insurers. The extent to which any potential solutions are pursued also may depend on an assessment of external factors including (1) the performance of the economy and growth of disposable income; (2) the development and acceptance (through mandated choice or otherwise) of innovative health plans; and (3) an increase in consumer understanding of health risks and insurance options.

The question of greatest concern is that of insurance for catastrophic illness or accident. Many individuals through insurance or other sources are able to bear the initial expenses associated with the onset of illness or accident, but when care is prolonged, insurance coverage may not be adequate and an individual's resources can be quickly depleted. Health financing reforms must address the appropriate source(s) of funding for necessary health services in these circumstances. The AHA, in this regard, supports the concept of catastrophic expense insurance.

At this point in the debate, there is little concurrence on solutions to the underinsurance question. AHA's preliminary assessment indicates that the following design considerations may be acceptable ways to mitigate potential underinsurance among the employed population:

1. Catastrophic expense limits should be required of all plans.
2. Employee rebates should be limited to 50 percent of the amount by which the actual employer contribution exceeds the cost of the plan chosen.
3. The required choice of plan should include at least one "low-option" and one "high-option" plan and one alternative delivery system, if available.
4. The present system should be continued, requiring all carriers to maintain minimum financial reserves or to post performance bonds.
5. Voluntary employee education programs should be promoted.

Adverse selection.—The adverse selection problem arises (1) when healthier persons, whose expected rate of utilization is low, consistently choose only basic (low-option) health plans, while individuals who represent higher health risks and who are expected to have high utilization rates consistently choose comprehensive coverage and/or (2) when low-risk persons with certain predictable health needs (e.g., elective surgery, maternity) switch between basic and comprehensive coverage in accordance with those needs. The potential outcome of this behavior is that the cost of comprehensive health plans could increase disproportionately, thereby pricing some employees out of the comprehensive coverage market. The problem may also arise when insurance carriers seek to minimize risk by being selective in enrollment practices, rejecting some higher health risks.

The fundamental policy issue presented is whether individuals who have fewer health risks should subsidize the costs of insurance and medical care for those with greater potential health care needs and, if so, to what extent and through what mechanism. Based on our preliminary evaluation, we believe the following options may help to minimize adverse selection outcomes among the employed population:

1. Periodic open enrollment should be required of all plans and all plans should be required to accept applicants.
2. Changes in enrollment by employees should be permitted no more frequently than once a year.

As we have stated, consensus on these questions does not yet exist. However, we are hopeful that continued Congressional interest and our initial attempts to answer these questions will stimulate insurers and others to bring forth their data and expertise to address basic design issues.

Medicare population

The federal government's continuing obligation to the health of the over-65 and the disabled populations, and the increasing costs of that obligation, require the inclusion of Medicare in discussions of consumer choice approaches. For Medicare, the objective of such approaches is to provide a choice of private insurance plan options for the eligible population. Several alternative mechanisms have been suggested to implement this objective, including direct federal contributions toward private health plan premiums or indirect contributions through a voucher approach. If insurers and providers respond as envisioned, they would probably offer lower cost health care plans to the elderly and disabled.

Arguments in favor of applying consumer choice concepts to the elderly include:

The current Medicare program has few incentives to control demand by beneficiaries;

Consumer choice could lend more predictability to governmental financial obligations;

Consumer choice could promote a more economically rational mix of benefits and continuity of care for beneficiaries, especially to the extent that it would encourage enrollment in alternative delivery systems; and,

Use of private insurance to underwrite the basic Medicare program could improve coordination of benefits and reduce the attendant administrative costs for beneficiaries who desire to supplement the basic Medicare benefit package.

For the above reasons, the AHA believes that a consumer choice approach based on federal contributions toward private health insurance should be a nationwide option to the existing Medicare program.

As with the employed population, a number of program design issues have been raised. These issues reflect concerns that the elderly, with generally higher health risks than the rest of the population, may have difficulty obtaining needed comprehensive health benefit coverage in the private insurance market. Such outcomes may reflect adverse selection tendencies and regional variations in actual experience and medical care prices.

These factors should be recognized. We suggest, to help solve the problem of adverse selection, that the federal contribution could be differentially valued on a regional basis and on the basis of age and sex.

Medicaid population

The voucher approach has also been advocated for use in the Medicaid program. Given the financial constraints of the Medicaid population, however, we question whether the consumer choice principles and fnancial incentives would have the intended effects. While segments of the Medicaid-eligible population may respond to certain limited economic incentives, e.g., nominal cost-sharing, the voucher concept is unlikely to elicit cost-conscious behavior from a population group that, by definition, has limited financial resources. Moreover, the economic and geographic transcience of the eligible population is likely to create complex administrative problems. We suggest that this issue requires substantially more examination—including indepth evaluation of such alternatives as private underwriting implemented through competitive bidding. Further study may uncover less administratively complex ways to bring the benefits of private underwriting to the Medicaid program.

OTHER ISSUES

Teaching and research

We would like to bring to the attention of this Subcommittee the particular concerns of hospitals engaged in medical research and the training of health care personnel.

Because consumer choice financing alternatives are intended to increase price competition among insurers and, in turn, among providers, some hospitals engaged in teaching and research may have difficulty financing these activities through patient charges. Alternative sources of financing may be necessary to cover these unmet costs. However, the response of the health care delivery system to a price-competitive environment cannot be predicted with certainty. It is possible that non-price considerations (e.g., quality, technological capability), as well as structural changes in the health care delivery system, would continue to define a unique role for teaching and research centers.

In any case, we must remain cognizant throughout these debates of the need to preserve a teaching and research capability adequate to meet the current and future needs of the country and to ensure continued progress in the improvement of the nations's health.

Charity care services

In many communities, hospitals are providing significant volumes of uncompensated services. This is especially true for public general and voluntary not-for-profit hospitals in the inner city and for many small or rural hospitals. For these hospitals, this mission often has led to situations of financial distress, due in part to the inequitable payment policies of Medicare and Medicaid which fail to recognize their proportionate share of these costs. It is not clear that, in a price-competitive environment, these hospitals would be able to attract sufficient numbers of paying patients to support their charity care loads.

Policymakers at all levels must recognize the continued obligation of government to assure access to needed medical services for the indigent. In the current political environment, however, individual communities may bear the brunt of this obligation. Sufficient flexibility must exist for these communities to determine the extent to which charity care obligations may be met through public subsidy, private philanthropy, or within the insurance system (e.g., risk pools, patient charges, etc.).

Maintaining opportunities for innovation

Some proponents of consumer choice reforms also envision a comprehensive restructuring of the health care delivery system according to legislative mandate. Such a mandate might limit certain organizational forms and give favored status to other forms deemed at present to be especially cost-effective.

We would note that hospitals are, and will remain, the health services centers of their communities, regardless of changes in the financing system. Proposals that would restrict the ability of hospitals to respond to enhanced market forces by developing or participating in innovative financing and delivery arrangements would be counterproductive to the health interests of their communities as well as to the economic goals of consumer choice reforms.

CONCLUSION

Mr. Chairman, the American Hospital Association appreciates the opportunity to present our views and recommendations to this Subcommittee. The AHA supports the principles of consumer choice and is committed to the thorough exploration of this concept's unresolved issues. Our staff are prepared to contribute whatever assistance this Subcommittee may deem appropriate and I will be pleased to answer any questions that you or the Subcommittee's members may have.

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

Mr. BROMBERG. I am Michael Bromberg, executive director of the Federation of American Hospitals. Submitting our testimony for the record, I would like to summarize a few points.

First, we see it as the purpose of this legislation which in concept we support strongly to change the incentives as Mr. McMahon said. The point to be made before that is that the existing system of financing has desensitized both providers and consumers to the true costs of health care because of the extensive use of first dollar coverage and low copayment payment rates. This is further aggravated by the cost reimbursement system, particularly medicare's. The result has been intense quality competition but very little price competition.

On page 3 of our testimony, we set forth four principles which we think should be used in changing those incentives. First, the patients must have a financial stake through cost sharing in order to bring some market restraint on decisions to utilize and choose plans. Second, the offering of multiple plans should be encouraged through a ceiling on tax free health benefits and through other incentives such as tax free rebates which could be limited in scope. Third, that the medicare program and medicaid should offer similar options such as HMO's, private insurance, and other alternative systems to Federal program beneficiaries at a fixed equal dollar contribution rate.

Finally, that the medicare cost reimbursement program for those who remain under it should also be changed to redirect incentives toward efficiency.

Looking at those four points, I would like to make just a few comments about the testimony we have heard from the last witnesses in opposition to this concept and point out a few things that I think were left out.

First, the concern that if we change the tax laws some people may go too far in choosing underinsurance. It seems to me that is inconsistent with another point made by that witness, which is that people want comprehensive insurance and experience has proved that. Second, it is inconsistent with 20 years of history of the Federal employees program upon which this program is certainly based. We have had that program in existence for 10 years. We have had 10 million people under it, including people on your staff. I do not think we have found any experience of underutilization or people making serious mistakes or being unable to choose insurance.

Third, I would like to make the point that I think something definitely has to be done about public hospitals that have a high degree of indigent patients but that you don't make national policy for 90 hospitals. You make an exception for them or a special procedure when you have 7,000 hospitals you have to look at the bigger picture.

The same goes for insurance. There are ways to address that through bonus payments or other kinds of reimbursement.

Without going into the tax policy, Mr. Chairman, I would like to switch to the voucher system. We believe it is the single most important reason we are here today. If it weren't for the Federal budget problem, if it weren't for increased Medicare spending and expenditures, I do not think the degree of interest in the competition or consumer choice proposals we have would be there. If that is why we are here, our first point is to urge you to include a medicare voucher option as part of any legislation seriously con[illegible]ered by this committee. We think this is the financing vehicle for changing incentives and we stress the word option. This is really nothing more than a national experiment. It will also address the complaint of the last witness that there is no consumer pressure for such a plan. If we give the beneficiaries the option, we will find out if they want it, how many want it, and no one will be hurt by it. That is the point I want to make more than anything else. These plans provide for a benefit package at least equal to medicare and if marketable, it is likely they will exceed medicare's package, that they will probably include without mandating it catastrophic insurance, prescription drugs and other kinds of benefits medicare does not provide in order to attract those patients, not fewer benefits.

Second, if it is an option the beneficiary not only has nothing to lose, he has an extra choice. If he or she does not like the program, they can switch back to medicare.

Second-class medicine could be changed. Right now the problems we have in this country of second-class medicine under the existing system relate to poor reimbursement. Questions of why patients get dumped in certain kinds of hospitals, about why doctors do or do not take assignment of certain patients, would go by the wayside if those patients walked in as privately insured patients the same as everybody else working in this country.

Finally, from the budget point of view the Government would know what the cost would be. It would be a premium payment, not open ended cost reimbursement. The incentives would be turned around. There would be no more rewards for spending or penalities for being efficient, but just the opposite under a voucher or negotiated rate system.

For the insurance industry, they would be challenged to see what benefit packages they could provide under the tax ceiling or for the voucher amount. For them a whole new market would be opened up. Less safe than being intermediaries, a little risky, but a brand-new market would be offered.

The adverse selection questions and other questions raised this morning I believe are adequately addressed in the legislation pending because they provide for an age adjustment, a sex adjustment, a geographical area adjustment and a health status adjustment so that the sick person used in the example by the last witness would get a much higher voucher than would the healthy 65-year-old living in a different part of the country.

Finally, if it makes sense to consider the competition approach at all for working people it seems to me it makes more sense to consider it for medicare. On page 16, we give our final recommendation on this which is that the Secretary be authorized to qualify private plans based on three criteria: One, an annual open enrollment period, two, a minimum benefit package reasonably equivalent to medicare's, and third, proof that the plan is financially viable or the posting of a performance bond so we don't have the kind of experience we did have in California with HMO's quickly developing that weren't checked out from a quality point of view.

We urge the committee to act favorably on that kind of legislation and hope also that at some point in the near future the committee will also address the medicare reimbursement system which I believe is directly related to the success of the competition approach.

[The prepared statement follows:]

STATEMENT OF MICHAEL D. BROMBERG, EXECUTIVE DIRECTOR, FEDERATION OF AMERICAN HOSPITALS

SUMMARY

We support a ceiling on tax free health benefits with the following recommended amendments:

(1) The amount of excluded income for employer contributions to a health plan on behalf of employees should be limited to a uniform dollar level adjusted annually for inflation.

(2) The rebate from selection of a lower cost health plan should be split equally between employer and employee in those cases where employers offer plans priced below the expenditure limit. This will help stimulate development of alternative health care delivery systems.

(3) Plans qualifying for a tax-free rebate should provide 90 days continuation of coverage after termination of employment.

We support a Medicare voucher option as the financing vehicle for offering consumer choice to Medicare beneficiaries. A federal payment or voucher would, at the beneficiary's option, be used in the purchase of private health plans (traditional insurance or alternative health systems).

The initial voucher amount should be the average per capita expenditure for Medicare beneficiaries adjusted for age, sex, area and health status.

We recommend that the Secretary be authorized to qualify private health insurance plans for Medicare financing based on the following criteria:

(1) An annual open enrollment period.

(2) A minimum benefit package which is reasonably equivalent to the Title XVIII benefit package.

(3) The plan has proved its financial viability to the Secretary or has posted a performance bond to protect beneficiaries and providers.

STATEMENT

Mr. Chairman and Members of the Subcommittee, my name is Michael D. Bromberg, Executive Director of the Federation of American Hospitals.

The Federation of American Hospitals is the national association of investor-owned hospitals representing over 1,000 hospitals with over 115,000 beds. Our member hospital management companies also manage under contract more than 350 hospitals owned by others. Investor-owned hospitals in the United States represent approximately 25 percent of all nongovernmental hospitals. In many communities, investor-owned facilities represent the only hospitals serving the population.

The common objective of the legislative proposals under consideration by this Subcommittee is to reform and redirect the economic incentives which impact demand and delivery of health care.

Our present system of health care financing has desensitized providers and consumers to the true costs of health care through the extensive use of first dollar coverage and low copayment rates. The situation has been aggravated by cost reimbursement which rewards excessive spending. The result is intense quality competition but little price competition. Restoring cost consciousness to providers and consumers is intrinsic to any solution to rising health costs. Without price awareness, demand for health services is infinite.

COST SHARING

A large body of economic analysis strongly supports the conclusion that financial incentives have a significant impact on utilization. Utilization goes down as cost sharing goes up. Here are some typical findings:

A 10-percent increase in the price of in-patient services reduces demand between 5 and 7 percent (Feldstein, Martin, "The Welfare Loss of Excess Health Insurance," Journal of Political Economy, 1974.)

A 100-percent decrease in the price of ambulatory services would raise demand by 120 percent. (Newhouse, Joseph, Charles Phelps, and William Schwartz, "Policy Options and the Impact of National Health Insurance," New England Journal of Medicine, 290 (1974) pp. 1345–1359.)

PRINCIPLES

The following principles should, in our opinion, be adopted to achieve a more effective health care financing and delivery system:

> (1) Patients must have a financial stake in the system—through some cost sharing of premiums and copayment of incurred cost—in order to bring some market oriented restraint to decisions on utilization and choice of plans;
>
> (2) The offering of multiple health insurance plans to all employed persons by employers should be encouraged through a ceiling on tax free employer purchased health benefits and through tax incentives, such as tax free rebates;
>
> (3) The Medicare and Medicaid programs should offer similar private health plan options—HMOs, private insurance, and other delivery systems—to Federal program beneficiaries at a fixed equal dollar contribution rate,
>
> (4) Medicare institutional reimbursement should be revised for services to beneficiaries who do not opt into a private plan. Cost reimbursement should be replaced by a prospective rate which rewards efficiency and penalizes inefficiency.

Unless these basic changes in approach are incorporated in any health insurance bill, we will aggravate existing disincentives for cost effectiveness and expand the underlying causes of inflation and increasing demand. Those underlying causes are cost reimbursement which discourages efficiency, third party payment with little patient financial participation which discourages restraint, and lack of competition among health plans and providers which discourages both efficiency and restraint.

Congress, upon enactment of Medicare and Medicaid fifteen years ago and until quite recently, perceived its role to be one of increasing and assuring access for the elderly and the disadvantaged to quality health care. That public policy decision, combined with a cost based reimbursement mechanism which rewards spending and penalizes efficiency, triggered the demand-pull inflation contributing to the inflation in the health care expenditures.

The hospital industry has simultaneously been hit with severe cost-push inflationary pressures for the past ten years and, in particular, following the expiration of the economic stabilization program in early 1974. Those major pressures included catch-up wages in a labor intensive industry; escalation of prices for the goods and services purchased by hospitals, particularly in food, fuel and malpractice insurance; a rapidly changing medical technology in which new diagnostic and therapeutic techniques and expensive new equipment are centered in the hospital; inflated material costs for hospital modernization and expansion programs; increased capital cost; and increased cost of compliance with government regulations.

Many industries have faced similar cost-push inflation pressures, but none have experienced simultaneously the increased demand for services similar to that triggered with enactment of the Medicare and Medicaid programs using inflationary cost based retrospective reimbursement payments for hospital services.

Even if the Administration ultimately succeeds in ridding the economy of inflation, federal and state health expenditures will still grow faster than tax revenues. For example, had there been no inflation over the period from 1977 through 1980, health expenditures would still have grown 14 percent in real terms. Of this amount, about 37 percent would have been due to population growth and 63 percent due to higher utilization per capita.

Because the proportion of the population over 65 will increase markedly over the next decade, the utilization of health care services per capita is expected to increase dramatically under the status quo. Medicare expenditures, even after being adjusted for inflation, are expected to increase by 60 percent from 1980 through 1985.

Since inflation can be dealt with effectively only by appropriate fiscal and monetary policy, health policy—to have the maximum beneficial impact—should focus on the next most important problem—utilization.

The decisions regarding health policy boil down to who should benefit, who should choose, and on what basis the choices should be made. Ideally, the beneficiaries should be both the individual patient and society as a whole. The choice as to the use of health care services should be in the hands of patients and their physicians. And, the basis of choice should be a combination of the best health interests of patients and society's interest that the extra value provided by extra services equal or exceed the extra cost.

The Federation of American Hospitals thinks that a ceiling on tax free premium contributions, a uniform employer contribution, and a Medicare voucher system would best strike the right balance between the patient's interest in getting good health care and society's interest that the value of health care benefits exceeds their associated costs.

TAX POLICY

Current tax policies devised to stimulate certain behavior often prevent the efficient delivery of quality health care. Financing of health care through income exclusions and deductions often results in apparent misallocations of health resources, while other Internal Revenue Code provisions and regulations prevent arrangements leading to more efficient use of those resources.

Many view the exclusion from employees' income of the employer contribution for employees' health insurance as a major factor in rising health care expenditures. Several bills introduced during the 97th Congress deal directly with the employer contribution issue and focus on tax laws as a potential catalyst for health care system reform. Current tax subsidies, over $20 billion in value, fuel the demand for insurance, utilization and unrestrained spending in the health field.

EMPLOYER CONTRIBUTION EXCLUSION

Presently, under Section 106 of the Internal Revenue Code, amounts contributed by employers for employees' health insurance are not included in the employees' income. This amount also is not included in the amount of employee pay subject to social security taxes. Consequently, employees have a great financial incentive to bargain for more costly, broad, employer financed health benefit packages. Taking compensation in the form of health insurance coverage allows employees to receive the full dollar of the employer's contribution. If, however, health insurance is purchased with salary paid by the employer, the employee receives after paying taxes only 50 percent to 70 percent of the same dollar of compensation. Since there is no limit on the amount of the exclusion, neither side—labor nor management—has any financial incentive to reduce health benefits nor provide less than first dollar coverage. Employees are not encouraged to seek benefit packages more specifically tailored to meet their health care needs, especially in light of the prevalance of group health coverage. Such broad coverage stimulates more frequent utilization of health care services and drives up health care expenditures. It effectively eliminates any cost consciousness on the part of consumers of health care.

Enactment of a ceiling on the employer exclusion would cause many employers to voluntarily offer multiple health plans including a low cost option. One incentive for the selection of low cost plans would be enactment of a provision authorizing tax free rebates to employees choosing low cost health insurance.

Eliminating the open ended employer contribution while encouraging equal contributions to all employee health insurance plans will stimulate competition among health plans and providers. Also, consumers of health care must have some financial stake in the system through some cost sharing of premiums and copayment of incurred costs in order to bring some market oriented restraint into decisions about utilization and choice of plans. Higher premium and delivery costs should be borne by the party selecting the plan or provider.

For these reasons we support enactment of tax amendments to limit the tax free exclusion from employee income of health benefits and to provide tax free rebates to employees who select lower cost health coverage.

We support a ceiling on tax free health benefits with the following recommended amendments:

(1) The amount of excluded income for employer contributions to a health plan on behalf of employees should be limited to a uniform dollar level adjusted annually for inflation.

(2) The rebate from selection of a lower cost health plan should be split equally between employer and employee in those cases where employers offer plans priced below the expenditure limit. This will help to stimulate development of alternative health care delivery systems.

(3) Plans qualifying for a tax free rebate should provide 90 days continuation of coverage after termination of employment.

CONSUMER CHOICE FOR MEDICARE BENEFICIARIES: THE VOUCHER OPTION

Medicare pays for about 16 percent of total personal health expenditures. Thus any discussion about health system reform or consumer choice legislation is incomplete, and possibly irrelevant, without the inclusion of Medicare-Medicaid reforms.

A consumer choice approach allows consumers to shape the health care system according to their own preferences as directly revealed in their purchase decisions. Government, which can never know consumer preferences as well as consumers themselves, is no longer necessary as an intervening agent. This procompetition strategy treats health care like other industries such as housing and food—basic necessities of life which are essentially unregulated except for government programs to help the aged and disadvantaged.

A VOUCHER SYSTEM

We support a Medicare voucher option as the financing vehicle for offering consumer choice to Medicare beneficiaries. A federal payment or voucher would, at the beneficiary's option, be used in the purchase of private health plans (traditional insurance or alternative health systems).

The initial voucher amount should be the average per capita expenditure for Medicare beneficiaries adjusted for age, sex, area and health status.

The voucher approach would in effect be a national experiment in consumer choice. The aged population would decide whether private plans are preferable to a government run system. A Medicare beneficiary would be entitled to have an annual election among qualified health plans or the existing programs. If not satisfied, the beneficiary could choose another plan the following year. States could elect to participate in such a system for Medicaid eligibles as the system progressed.

Although the voucher system is new to health care financing, the basic idea is very familiar to the public. Dollar bills are vouchers. The only difference between a thousand dollar bill and a thousand dollar health insurance voucher is that the money can be exchanged for anything but the voucher only for health insurance.

BENEFICIARY RIGHTS

The consumer choice approach for Medicare-Medicaid patients would produce major changes in the access and influence of the aged and poor in the health marketplace. By arming these patients with vouchers and private insurance or membership in health plans, the proposal will change the attitude of health providers toward these patients. Second class medicine in America is simply an economic term meaning patients for whom reduced payment and increased regulation are imposed by government on providers. The problems of physicians refusing to take Medicare assignment or refusing to see Medicaid patients and the "dumping" of Medicaid patients in public hospitals are the direct result of inadequate government reimbursement.

Under a voucher system, these patients would be viewed as equal to all other privately insured consumers, increasing their access to quality health care and their influence over the system.

BUDGET IMPACT

From the government's perspective a voucher system means fixed premium payments in lieu of open-ended reimbursement. This should not only make government spending more predictable but also it will reduce administrative costs. Also, the voucher system would help assure that government health care budgets provide beneficiaries with the best health care possible for the dollar—much better than what they would receive under the status quo. This would happen because use of vouchers encourages innovation in health care delivery—the best hope for better health care at less cost—and forces providers to consider the patient's economic as well as health interests.

PROVIDER IMPACT

A voucher system would impact health providers in several ways. Government regulation and disputes over cost reimbursement rules would be replaced by health plan negotiations for fixed payment rates. the prices of health providers would become more visible and subject to consumer pressure through their choice of health plans. Providers would be more accountable to the public and would have to justify pricing practices to consumers who would be sharing part of the costs involved in their care.

IMPACT ON INSURANCE INDUSTRY AND HEALTH PLANS

The insurance industry and health plans would be challenged to market private plant to the large segment of the population now covered by government. Innovative benefit packages would be designed to compete with the existing Medicare-Medicaid benefits. Outpatient drugs, unlimited hospitalization, and nursing home care are three examples of benefits which Medicare does not adequately cover for senior citizens. A plan which adds this kind of coverage might be more attractive to a beneficiary than existing Medicare coverage plus out of pocket payment for supplemental insurance.

Health maintenance organizations would also have the opportunity to market to these beneficiaries in direct competition with traditional insurers and with the government plan.

ADVERSE SELECTION

There are many questions which must be addressed before a voucher system is fully implemented. These include the adverse selection problem which could result if most younger Medicare beneficiaries exercise their option to buy private insurance while older, high risk patients remain in the government program. This can be addressed by adjusting the amount of vouchers for age, sex, area and health status differentials; by qualified private plans including catastrophic coverage; and by providing an annual open enrollment period.

If it makes sense to encourage employers to offer a multiple choice of competing insurance and other health plans to their employees, then it makes even more sense to ask government to offer the same choice to its beneficiaries. If it makes sense to offer incentives and tax free rebates to employees who select cost effective insurance or health plans, then it makes sense to offer similar incentives to government program beneficiaries. If the marketplace can be made to work in health care delivery to employed persons, it can certainly do a better job than government regulations in health care delivery to federal program beneficiaries.

The consumer choice/pro-competition proposals now pending in Congress and the bill now being prepared by the Reagan Administration offer a new idea to alleviate the problem of health costs. The future fiscal integrity of the Medicare trust fund as well as the ability of general revenue financing to pay for the health needs of the poor, require us to take a look at fundamental Medicare-Medicaid reforms in designing an effective consumer choice bill.

We recommend that the Secretary be authorized to qualify private health insurance plans for Medicare financing based on the following criteria:

(1) An annual open enrollment period.

(2) A minimum benefit package which is reasonably equivalent to the Title XVIII benefit package.

(3) The plan has proved its financial viability to the Secretary or has posted a performance bond to protect beneficiaries and providers.

A Voucher option provides us with a way to make the health care system more cost-effective at no risk to federal beneficiaries.

We urge the Committee to act favorably on a Medicare voucher option bill similar to the legislation proposed by Representatives Gephardt and Gradison.

MEDICARE REIMBURSEMENT

We urge the Subcommittee to revise the Medicare hospital reimbursement system in order to replace retrospective cost reimbursement with a prospective payment which is consistent with the competition approach. Specifically we recommend an indemnity insurance method based on a Medicare prospective payment equal to a percentage of areawide charges with hospitals allowed to charge the beneficiary the differences between that payment and their usual charges.

This method would be easy to administer and would produce competition among hospitals to meet the target rate or compete over the differences between that rate and its own charges compared to other hospitals in the area. By using a percentage of unit charges rather than average costs or charges per admission, the program could avoid the necessity of developing a complicated clarification system, adjustments for differences in intensity or patient mix, or an exception procedure.

We would be pleased to work with members and staff of the Committee to develop this kind of prospective payment system.

DEREGULATION

By eliminating cost reimbursement and its inherent lack of incentives to restrain capital spending, we would also be effectively eliminating the need for any Federal certificate of need process. Other types of regulation, particularly State rate setting, would be inconsistent with the market approach of a consumer choice system. For these reasons we support repeal of the Federal Health Planning Act and enactment of a provision authorizing the Secretary to override State certificate of need or rate setting laws which interfere with the effective implementation of the competition legislation.

We thank the Chairman and the Subcommittee for this opportunity to present our views on proposals to increase competition in the financing and delivery of health care.

STATEMENT OF JOHN HOFF, GENERAL COUNSEL, NATIONAL COUNCIL OF COMMUNITY HOSPITALS, ON BEHALF OF JOHN F. HORTY, PRESIDENT

Mr. Hoff. I am John Hoff, counsel to the National Council of Community Hospitals. I am pleased to appear before you today to discuss these new ideas.

There is one message I hope the committee will hear today and during the other 2 days of these hearings—the health care financing and delivery system must be fundamentally reformed. I think there is very little disagreement from anyone on that issue. The real debate, what you are hearing this morning, is whether that reform should be more regulation or whether a new approach, deregulation and economic competition, should be tried. I think the hospitals of this country have come to a strong conclusion on that choice as the result of their experience.

[Discussion off the record.]

Chairman Jacobs. Mr. Hoff, shall we resume your testimony? Apparently the prognosis is good.

Mr. Hoff. Thank you, Mr. Chairman.

I was saying that the hospitals of this country have had sufficient experience with regulation of their activities that they believe the further regulation would make the system less efficient, not more, and would reduce the quality of care. Elaborate tinkering by regulation with what is basically a fundamentally unsound system will not work. Regulation has not worked and there is no reason to believe that more of it will work any better. Instead of continuing down the present path, the basic economic structure of the system must be changed. That means one first principle; reasonable cost reimbursement as provided by the Government must be eliminated. Reasonable cost reimbursement is an incentive to providing more units of services at the same time the Government is underfunding hospitals for providing those services. Hospitals are paid on a cost minus basis for medicare patients. Instead of being told they will get the reasonable costs of providing a service, hospitals and doctors should be forced to compete in terms of price as well as quality.

To make price competition work, patients must also be made cost sensitive. They must have an economic stake in choosing the form and method of delivering their health care. Basically to somewhat elaborate on what Mr. McMahon was saying and to go one step further, I think that consumer choice and competition are inextricably intertwined.

The Federal Government must continue its commitment, while engaging in a competitve system, to those in society who do not have the money to pay for health care. It should end the discrimination in the Tax Code against those who do not receive employer paid benefits. The Federal Government will get more for its dollar if that money is funneled through a competitive system than if it continues to be siphoned off through the present cost reimbursement system.

The contribution must go directly to the beneficiaries so they know how much it is and so shortfalls cannot be disguised by cutting back on hospital reimbursement as is now being done under medicare and medicaid.

Because its members believe that these fundamental changes are necessary, NCCH strongly endorses H.R. 850. This bill addresses the deficiencies of the present system. It would make the changes necessary to give people the ability to make their own decisions on how they want health care delivered and how much they want to pay for it and institute a cost sensitive, patient responsive system.

This morning I have heard two criticisms about the bill which I would like to discuss briefly.

The first is that people do not have the ability to choose their own health care plans. We have more confidence and more faith in the ability of the American people to make their own decisions. If they want to hire experts or get the advice of experts, the bill provides a mechanism for this. Nor is it true to say that the bill excludes employers or unions from the purchasing processes. Employees could choose, if they wished, to turn the decision over to their employers or to their unions and, in fact, the premiums that the plans would be permitted to charge could be reduced to reflect the administrative savings that have been mentioned.

Also, there has been some discussion about this bill as being a tax increase bill. I think that is unfair. In the first place, the changes are made, I think as Dr. Rivlin suggested, in order to bring cost sensitivity to the market and to make decisions tax neutral rather than to raise taxes. It would make people decide at the margin whether or not they wanted more wages or more health insurance with that decision not being skewed by a tax system which has encouraged them to go in one direction.

Second, it has also been overlooked that the bill provides substantial tax relief to the people who most need it to obtain health care. Forty million Americans now receive no Government assistance in obtaining health care. By providing a tax credit, the bill helps those individuals.

The health care field is not familiar with economic competition but we believe its members—hospitals, patients, nurses, doctors, and allied health personnel—would respond to a decision in this direction with innovation, spirit, and determination. New systems would be developed by these committed people which would provide care in a more comprehensive, unified, and cost sensitive manner.

Thank you, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL COUNCIL OF COMMUNITY HOSPITALS

My name is John F. Horty. I am President of the National Council of Community Hospitals, 1735 I Street, N.W., Suite 710, Washington, D.C. 20006, (293-6195). I am pleased to appear today to discuss legislative proposals to reform this country's health care delivery system.

NCCH is an organization of more than 100 community hospitals from 28 states ranging in size from 40 to 1000 beds. It was organized more than six years ago by a number of innovative health care leaders who saw the need to develop new ways of delivering and financing health care in this country. Our members have played a leading role, I think it is fair to say, in formulating, propounding, and refining the ideas that are being discussed today as "competition."

TOPICAL OUTLINE

NCCH hospitals have concluded that the continuation of quality health care in this country at an affordable price for all, requires major restructuring of the finance and delivery system. Reasonable cost reimbursement is the wrong way for the government to assist Americans in obtaining health care -- wrong both for the Government and the hospitals. The regulatory system which has been imposed on hospitals is ineffective, expensive, intrusive, counter-productive, and contrary to good management. The only way to bring economic sense to the system is to phase out reasonable cost reimbursement, phase out Government planning, and institute economic competition which will make both providers and patients economically sensitive.

This society has made a commitment to the poor and the elderly to provide them assistance in obtaining health care. We stand behind this commitment. It should continue and in fact be expanded and equalized, but it must be structured in a different way. The fact that the Government assists people in obtaining health care should not, and does not, entitle the Government to control the way the care is provided or artificially effect the price of that care. The Government's role should be that of providing the amount of money which it determines to make available to help people. To ensure that the Government obtains value for the large amounts of money it expends, it should insist that its assistance be used to obtain health care in a competitive market.

We believe the best way to achieve these goals is to require providers of care to compete on economic as well as on quality grounds, forcing them to bear the consequences of inefficiencies and giving them the benefit of their efficiencies; to let the people decide how much they wish to spend for health care and how they wish it delivered, considering the cost as well as quality; and to tie Federal assistance to those marketplace decisions in a way that leaves both providers and patients cost-sensitive. Introducing economic competition into health care is designed to achieve these goals.

There is one comprehensive competition bill before this Committee, the National Health Care Reform Act of 1981, (H.R. 850). We strongly endorse that bill.

Congressman Gephardt of this Committee has performed a great service to the people of this country in developing legislation which would bring economic disciplines to the health care field and at the same time help all Americans to obtain care. The development of H.R. 850 (and its predecessor, H.R. 7527) by Congressman Gephardt and then-Congressman Dave Stockman was a heartening example of a bi-partisan effort to solve a major national problem. We are pleased that other distinguished members of this Committee, Congressmen Gradison, Heftel, and Moore, have joined in that effort, as well as Congressmen Corcoran, Gramm, and Porter.

We urge this Committee to give the National Health Care Reform Act early and favorable consideration, and we look forward to working with the Committee in that effort.

I would like to explain in more detail why the bill is essential, why it presents the most feasible solutions to the problems of the health care field, and then to discuss some particular aspects of the bill which require particular discussion.

The Need for Reform

The health care delivered in this country is unequaled in the world. But our health care can be made better still, particularly by filling the gaps in coverage, and it can be made financially more responsive.

The basic problem with the existing system is that there is, in fact, no system. Health care is delivered by institutions and individuals who are not coordinated into a unified system. Often, no one person is responsible for coordinating the care of the individual patients in a particular acute episode. Nor is any person responsible for providing preventive and follow-up care. Even within a hospital there is no unified system. Hospitals provide a place for doctors to practice and support their efforts, but doctors in large part perceive themselves as independent of the hospitals and feel little identification with the hospital in which they practice.

The economic system under which health care operates is expansive and encourages the provision of expensive care. Health care is necessarily costly, but the present system provides little positive incentive for either doctor, hospital, or patient to consider the cost of health care. Patients need not consider the cost because so much of it is paid for by third parties -- insurance and government. Even insurance is in large part purchased by persons other than the patients, particularly by employers. And employers and employees are encouraged to provide ever-more insurance by tax laws which are skewed to favor compensation in the form of insurance rather than cash wages.

Doctors and hospitals themselves in large part are not at economic risk. Hospitals have no incentive to deny the patient or his physician anything he asks for. Hospitals and doctors have no incentive under the reasonable cost/reasonable charge reimbursement system not to provide more units of services. The more services they provide, the more they are paid. At the same time, because they are not being paid fairly under reasonable cost reimbursement, providers, particularly hospitals, must increase the number of units of service they provide in order to survive.

The reasonable cost reimbursement system is at one and the same time too generous and too restrictive. No organization, not even a not-for-profit organization, can continue to survive, particularly in inflationary times, if it is reimbursed only for the "cost" of providing a service. This does not leave the necessary excess of revenues over expenses needed for working capital, contingencies, replacement of plant and equipment, and even for borrowings. Thus, even if reasonable cost reimbursement were fairly applied, not-for-profit hospitals would be financially strapped.

But the Government, faced with its budget crunch and concerned about the open-check aspect of reasonable cost reimbursement, has not paid hospitals even their reasonable cost. By a series of regulatory measures and unilateral refusals to pay actual costs, the Government has reimbursed not-for-profit hospitals susbstantially less than the cost of taking care of Medicare beneficiaries and has refused to pay its share of the overall financial requirements of hospitals.

Hospitals must make up the shortfall in reimbursement from the patients of the hospital who pay charges, a relatively small percentage of most hospitals' patients. The private, charge-paying patient is cross-subsidizing to a significant degree the cost of taking care of Medicare and Medicaid patients. This is one of the major causes for the dramatic increase in hospital charges, and, because not all hospitals have enough charge-paying patients to recoup these shortfalls, of the financial weakness of many hospitals.

While most hospitals therefore are reimbursed by the government on a cost-minus basis, for-profit hospitals are reimbursed on a different basis; they receive the same reasonable cost as not-for-profit hospitals do, plus a payment for a return on equity, which is now running at approximately 20%.

To offset the open-ended nature of reasonable cost reimbursement, and spurred by its own fiscal difficulties, the Government has imposed increasingly intrusive regulation on hospitals. The "planning" process upon which the Government has embarked in recent years is nothing but a euphemism for command and control regulation of every detail of hospital activity. Hospitals have become the most regulated activity in this country.

Even if planning were administered in an objective and balanced basis, it would not work. Health care is far too complex, too variable, and too rapidly changing to be managed by outside regulatory groups. There is no objective reality to be applied by them. There is no right answer on how many CT scanners there should be in an area or how many hospital beds should be available. The result is confusion, arbitrary and erroneous allocation decisions, and intrusive interference in hospital management by people who do not have the necessary expertise and do not bear the responsibility for the effects of their actions on the quality and efficiency of health care.

Worse, the planning process has not truly attempted to balance the need for expansion, modernization, and new services. The driving thrust of planning has been to impose short-sighted measures believed to save money, to the exclusion of other factors, as well as to enforce particular social agendas of the moment.

The nature of health care is being determined by Government and its agents. To an increasing extent medical care decisions are being made on the basis of political considerations or by bureaucratic decree, neither of which process enhances the well-being of hospitals, physicians, or their patients. This political/bureaucratic process is deciding such questions as who builds what facility, who purchases what equipment, which hospitals grow and which hospitals die, how revenues are allocated, how long patients stay, what services are provided, and how much hospitals are paid.

The Options Available

There is widespread recognition of the effects on cost of third-party reimbursement, unlimited and unconditional exclusion from tax of employer-paid premiums, and reasonable cost reimbursement. The only real issue is what changes should be made to increase concern for cost among those who participate in the system. There are those who believe that health care must be regulated even more tightly and the power of the regulators be increased in order to counteract the uncompetitive nature of the financing system. They would add new excrescences to the regulatory structure to squeeze the system into the desired mold, despite the pressures of the underlying incentives. Regulation has not worked, yet they would add new regulation. On the other hand, there are others who believe that the answer is not to subject the system to more regulation, but to change the economic underpinnings and so make that regulation unnecessary.

It is important that society choose. The present arrangements are unsatisfactory and unstable. Regulation is disrupting and distorting the delivery of care but Government has been pressing for more. Both the Government and the health care field, and most importantly the country as a whole, need a decision as to whether we want our health care system run through command and control regulation by the Federal Government of every hospital in this country or whether we want to let patients and providers, controlled by marketplace disciplines, work out the most efficient way of delivering care.

Hospitals' first-hand, painful experience has convinced them that regulation is expensive, inflexible, and ultimately self-defeating. We believe, and I think most Americans believe, that regulation is not the answer and that the disciplines of the marketplace can operate in health care if not prevented from doing so by government programs.

H.R. 850 represents a proposal for deregulation and competition.

A Program for Deregulation and Competition

H.R. 850 is based upon the premise that there is no one "right way" to deliver health care or "right amount" of resources devoted to health care and that the American people should be free to make those determinations by choosing from among competing delivery systems, with that choice being guided not only by quality concerns, but cost as well. The bill contains a number of inter-related provisions to reach this result.

The bill funnels Federal assistance for the purchase of health care plans through qualified plans, competing in terms of price and quality. To ensure that Federal money is used for appropriate protection, the bill requires that qualified plans must provide basic acute care services, plus catastrophic coverage. Plans would set a price prospectively: they would agree to provide health care for a pre-paid amount, which removes any economic incentive to provide unneeded services. The plans' price will be determined competitively. This will put them at risk for their efficiency and quality. The inefficient plans will be identified by their price, and are unlikely to survive in a competitive environment.

Plans will have to balance the cost of new equipment or new buildings against the need and members' willingness to pay the cost. Under price competition, duplicative facilities are unlikely to be built, and unnecessary equipment is unlikely to be purchased. Conversely, if there is a need for new equipment or new services and the plan believes the people will pay the added cost, it will incur the expense and the risk to modernize.

To be cost effective, furthermore, plans will enter into a variety of new arrangements with hospitals, doctors, and allied health personnel to provide quality care at a competitive price. A variety of innovative delivery systems which are not even known today are likely to emerge.

The bill would also increase patients' sensitivity to the cost of care. To make price competition meaningful, members would be encouraged to compare plans in terms of cost and quality. The bill addresses the various categories of members differently.

Employees whose employers pay their health premiums would be permitted to make their own choice of health plans and have a financial stake in the decision. They would be free to obtain as much insurance as they desired, but if they opted for more than the average amount obtained by other people of the same actuarial category in the same area, they would pay for the marginal amount with after-tax dollars. By the same token, an employee choosing a plan which cost less than the average (but still provided the benefits required of a qualified plan), would receive the difference in tax-free cash.

While the bill enables individual employees to make their own choice of health care plans and provides information for them to do so, it also lets them receive the benefits of group purchasing. To the extent that group purchases of insurance provide administrative savings, the bill would permit plans to reduce the premium that would otherwise be charged to a member of an actuarial category to reflect those savings. The bill allows individuals to weigh the benefits of individual choice against the savings of group purchases.

These provisions would enhance price sensitivity among employees who receive employer assistance. It also would make the decision between receiving health benefits and cash wages tax neutral, ending the provisions of tax law which skew the decision toward insurance by making employer-paid health insurance tax-free regardless of the cost and which thus discourage workers from taking cash wages. The unlimited and unconditional tax subsidy given health insurance is unique in the tax law and favors workers whose employers provide health insurance at the expense of those workers who do not receive this benefit. H.R. 850 continues to provide tax assistance to employer-paid health premiums, but limits this assistance in order to introduce price sensitivity, restrain health care inflation, and increase tax fairness.

H.R. 850 also provides a tax credit for Americans who do not have other forms of Government assistance to use in obtaining health insurance. This will improve access to care and end an unfair discrimination in the tax code. There are over 40 million Americans who obtain no Federal assistance in obtaining health insurance because they are self-employed or work for employers who do not pay their premiums. They either cannot pay for health insurance or must pay with after-tax dollars, while other workers obtain insurance with tax-free dollars. The bill provides a tax credit to end this discrimination and help these Americans obtain health insurance through qualified plans. The tax credit would be in an amount approximately equal to the tax value of the exclusion provided to employees whose employers do contribute to plan premiums.

For price competition to be truly effective, reasonable cost reimbursement must be ended. Patients who receive and providers who deliver care under open-ended reasonable cost/charge reimbursement are less likely to be cost-conscious than those who are under competing plans. There cannot be marketplace competition if reasonable cost reimbursement is not ended.

H.R. 850 provides a mechanism for ending Government's utilization of reasonable cost reimbursement under Medicare and Medicaid. It gives the beneficiaries of these programs the option to participate in the competitive system, and thus the opportunity to choose among competing plans. As they elect to take advantage of this opportunity, reasonable cost reimbursement would be phased out, and the Government would have the benefit of its assistance to these beneficiaries tied to a more efficient, cost-sensitive competitive system.

The plan gives the Medicare beneficiaries a choice, and makes them cost sensitive in making that choice. The voucher provided them would be equal to the average amount spent by other beneficiaries in the same actuarial category in the same area. If a beneficiary selected a plan which cost less than the amount of the voucher, he would be entitled to a refund for the difference.

Finally, the bill would enable Medicaid beneficiaries, after a transition period necessary to have the competitive system in place and operating, to participate in the competitive system and join the same plans as the rest of the community. If a State chooses to join the program created by the bill, Medicaid acute care would be federalized under a national standard of eligibility for low-income assistance. The inequities of the present Medicaid system would be reduced since Federal assistance would be made available on an equal basis to residents of all States with adjustments for local variations in costs. States would be relieved of the continuing and projected increases in their Medicaid acute care costs.

Medicaid beneficiaries would receive a voucher to use in paying the premium of any plan they chose. The amount of that voucher, like the other forms of Federal assistance, would be equal to the average coverage of other members of the same actuarial class in the same area joining qualified plans, plus an amount prospectively to take care of co-payments, so that Medicaid beneficiaries would not be required to make any out-of-pocket expenditures. In this way, Medicaid beneficiaries (in a State electing to participate) would be assured of receiving assistance from the Federal Government to use for health insurance in the same amount.

By these measures, the bill phases out reasonable cost reimbursement and places providers at economic risk, while giving assistance to all Americans to obtain health coverage in a way that ensures that they will be cost-conscious in choosing among competing plans.

It is sometimes said that people will not be able to choose among competing plans. We reject that suggestion. We believe the American people can make choices about their health care in a diverse and pluralistic market, just as they do in other activities in life. Patients now choose doctors and can consider which hospitals to use. Apparently there is no complaint about their ability to do so at the present time. The bill does not interfere with that choice. It merely would add the cost component to the equation. In addition, the bill provides a mechanism for people to delegate the choice of plans to experts if they wish to do so.

To permit competition to work, on the other hand, the regulatory superstructure must be dismantled. Competition cannot work if there are economic barriers to competition, such as planning or rate review. The bill terminates the Federal planning control imposed on hospitals, and it prohibits the States from engaging in planning controls or otherwise restricting the ability of plans and providers to make their own economic and management decisions. It explicitly preserves State requirements, such as licensure of health professionals and health facilities, which promote the safety and quality of health care. This is an important provision designed to ensure that the quality of care is protected by regulation while the economic aspects of the system are deregulated.

The bill contains other provisions to promote competition and increase access. In order to prevent qualified plans from choosing the preferred risks and competing on risk selection rather than efficiency of operations, it requires them to accept applicants regardless of risk status. People can be counted upon to exercise this right. In addition, the bill reduces the incentives for plans to risk-select by permitting different premiums to be charged for different actuarial categories (defined by age, sex, and number of dependents) and tying the Federal assistance to the costs of each actuarial category. The bill protects plans from receiving a disproportionate share of high risk patients by directing the Secretary of HHS to redistribute such risks among the plans in an area if one plan is adversely selected against.

H.R. 850 balances two different and competing social values: on the one hand, it permits people to select insurance which suits their individual needs and on the other hand it provides for risk sharing among individuals. These two goals necessarily conflict, and must be balanced. We believe that H.R. 850 provides a proper balance. By basing premiums and Federal assistance on actuarial categories, it reflects the separate risk status of the different actuarial categories, but by making the categories broad it provides for risk-spreading among members of different ages within an actuarial category.

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One concern which must be resolved centers around the possibility that even with the availability of increased Federal assistance, some people may not have sufficient funds to pay for their health care. Hospitals and physicians, as they do now, will provide care for free or for reduced payment. The need to recoup these expenses would be an impediment to fair competition for hospitals with a disproportionate share of them and would threaten their ability to continue providing care. H.R. 850 recognizes this problem with respect to people who are not members of a plan and provides for partial Federal assistance to providers who incur bad debts in caring for non-members. The problem can arise in other ways as well.

One problem could arise during the period when Medicare and Medicaid are still functioning. Medicare and Medicaid, while supposedly based upon reasonable cost reimbursement, actually do not pay hospitals the cost of taking care of those beneficiaries. Those hospitals which serve large numbers of Medicare and Medicaid patients, therefore, have substantial shortfalls from the Government's programs which they are now able to make up only from private charge-paying patients. In the transition period of a competitive system, before Medicare and Medicaid have been phased out, hospitals which care for large numbers of Medicare and Medicaid patients would have to raise their price to offset those shortfalls; hospitals that did not have those shortfalls would not. The difference in price could put the hospitals serving substantial numbers of Medicare and Medicaid beneficiaries at a significant competitive disadvantage. This would create unfair competition and in not too long a time, as their financial stability was eroded by the shortfall of Medicare and Medicaid reimbursement and the loss of the commercial charge-paying patients, to the reduction of care for the Medicare and Medicaid beneficiaries.

Even if Medicare and Medicaid are phased out, there will be differences in providers' bad debt experience arising from members who do not make the co-payments required of them under the plan they joined.

We suggest to alleviate these problems that qualified plans be required to absorb the bad debts of the hospitals and physicians and other providers who provide health care to their members and (during transition) the Medicare and Medicaid shortfall of these providers. This would spread the cost among all those in a community who join the plan and permit fair competition among various providers with respect to plans. There is the further danger that a particular plan could be affected disproportionately by such a provision. This could be avoided by equalizing a plan's disproportionate

Medicare/Medicaid shortfall and bad debts (if the plan has made commercially reasonable efforts to collect them) among all qualified plans in an area -- in effect a pooling of the cost of health care of the poor among all plans receiving the benefit of Federal assistance to their members.

* * * *

We think it is essential for this Committee in its deliberations to recognize that there are really two issues Congress must decide: 1) the structure of the health care delivery system, and 2) the extent to which the Federal Government will assist Americans in obtaining health care.

The system needs to be reformed, regardless of the amount of Federal assistance provided to its beneficiaries. The Government already is underfunding those who provide services to Medicare and Medicaid beneficiaries, and it threatens further cuts. The fact that it may make those cuts is by itself no reason not to reform the delivery system, but competition cannot be seen as a vehicle for the Government to reduce its commitment to Medicare and Medicaid beneficiaries. If the assistance is too low, people will not be able to obtain care, and competition will not be accepted. The savings must come from institutional reforms, not short-term changes in the Government's assistance to its beneficiaries. In fact, we believe that the Government's concern over its expenditures for Medicare and Medicaid expenditures dictates that basic structural reform must be made, or at least begun: over the long-run its assistance will go further if the system is made more efficient, responsive, and cost effective, as it would be by the reforms proposed in H.R. 850.

That is not to say, however, that costs necessarily will go down if the reforms are made. The present system has been badly underfunded and hospitals, particularly those caring for large numbers of poor patients, are severely undercapitalized. It may be that the people will decide to spend more for health care than the government would otherwise itself be willing to pay. They should be free to do so, if those decisions are made on an economic basis, as they would be under H.R. 850. The bill removes the cost-increasing incentives of the present system, but does not dictate how much the people may wish to spend for health care.

* * * *

The health care system cannot continue in its present regulatory, reasonable cost reimbursement mode. This system is not cost effective. It forces hospital managers to conform their conduct to arbitrary, vague, and constantly changing reimbursement rules and to intrusive planning control and prevents them from doing what they want to do, and society should want them to do -- managing a comprehensive system of health care delivery.

Competition and deregulation will bring economic discipline -- a far more effective tool than Government intervention. It will permit millions of individual decisions by those most directly concerned in health care to determine how care is delivered -- a far more effective mechanism than centralized Government decision-making.

Competition is already beginning to occur. But it is coming slowly. The barriers to competition created by the tax treatment of insurance, planning, rate review, and reasonable cost reimbursement must be removed. Only a comprehensive approach such as H.R. 850, which treats the various inter-related problems, can do so. A critical mass of patients, hospitals, and doctors participating in the new system is necessary for it to begin to truly operate. H.R. 850 provides the vehicle for obtaining this critical mass: its passage would send the essential signal that the Government has decided that health care delivery should be competitive; the bill, by channeling Federal support for the purchase of health insurance to that system, would provide a major incentive for change.

Reform will not be easy. But it is necessary. The hospitals of this country recognize that new structures will have to be developed. They realize that painful adjustments will be necessary to make fundamental reforms in such a complex and vital sector of our society. But the health care field, given the opportunity, will respond with commitment and with managerial innovation to put in place more responsive, more unified, and more efficient forms of delivering health care.

Chairman **Jacobs**. Mr. Duncan?

Mr. **Duncan**. Thank you, Mr. Chairman.

I want to thank the panel. All of you, as usual, did a good job in your presentation. I have just one question. Anyone of you may answer. What do you believe should be done by the Government or the private sector to protect hospitals with special problems such as large public hospitals, teaching hospitals, or pediatric hospitals from severe consequences that may result from implementing the competitive ideas?

Mr. Bromberg?

Mr. **Bromberg**. Let me make a couple of points, Mr. Duncan. I think the first point is that since medicare was enacted 16 years ago, it has ignored the issue of the bad debts and its obligation to share in the bad debts of hospitals other than for medicare patients, which means that hospitals with a high percentage of indigent patients cannot look to medicare for any help whatsoever. It seems to me that that is the key, that we are not going to solve the problem with grants and bailout programs or anything else other than money.

It seems to me that the best way to do it would be to start with the present medicare reimbursement system and admit that we can't afford it. It would cost over a billion dollars if medicare were to pay for all bad debts, and we are obviously in a climate where that is not realistic. Maybe we could afford part of it. Maybe we could say hospitals that have an excessive amount of bad debts, because they have a higher than normal amount of indigent patients, should get reimbursed something from medicare for that 1, 2, 3, 4 percent on a sliding scale. Maybe we could spend $100 million to start with and help those, as I said, relatively small number of hospitals compared to the lot.

The second thing we could do is under a voucher system provide something similar where there is a direct program. I believe H.R. 850 has a grant program for teaching education and research which would help indirectly, but I have some problems with how you allocate the big pots of money once they are collected fairly. Whereas this could be on a strict formula basis. I think bad debt reimbursement is the key.

Mr. **McMahon**. Mr. Duncan, the problems that you identified at public hospitals, many of the pediatric hospitals, grow out of the fact they are doing a lot of charity care. Many of them are distressed because they are underpaid by the medicaid program or the medicaid program in the locality where they exist is inadequate. In some of the earlier discussions Mr. Gephardt noted the provision of his bill that would, along with the savings in those other programs, increase the medicaid standards.

I think that would go a long way to doing it. Even some of the institutions with a substantial percentage of medicaid, with underpayment, and then the lack of eligibility, the free care they provide, I am not sure with many of the institutions that they can recover enough from the other programs even if the other programs shared in bad debts. It is a very special kind of problem, but the problem lies in an improvement of the medicaid program or perhaps the modification that will come along with what you have all done in the omnibus bill; in effect, turn to the States and say you have some hospitals with some particular problems; that may lie in challenging the patients to the public hospitals and adequately paying them for the result.

With respect to the speciality hospitals, I think their survival will depend upon linking up with some of the other institutions in a referral setting and there is certainly a possibility there.

Mr. **Hoff**. Mr. Duncan, I think the problem of financial—Government financial assistance to the poor is a problem under any system. It is a problem under the present system, and it is getting worse. I think the point to be made is that under competition, the Government decision on how much money it is going to pay would be there to be seen. We hope that it would be an increased amount from what is happening now, but it is a problem in any system.

Furthermore, I think the competitive system is going to have to share the bad debts, if they become disproportionate, among the people in an area to prevent some people, including particularly the inner city hospitals, from having a disproportionate share of bad debts and therefore having a greater difficulty in competing for the other business.

The teaching hospitals, the costs of teaching are now being submerged, included, merged with patient care reimbursement. The bill H.R. 850 contemplates a grant program and the teaching hospitals, I think, will testify later that there is some question on how the grant mechanism should be put in place, but basically that is the direction, I think, they are going to want to go.

Specialty hospitals should not be a problem because under a competitive system, people will be—plans will be competing, if you will, to be tied up with the major children's hospital, whatever it is in an area. People will want to be able to use that hospital.

Mr. **Duncan**. Thank you very much. I have no further questions, Mr. Chairman.

Chairman **Jacobs**. Mr. Gephardt.

Mr. **Gephardt**. Thank you, Mr. Chairman.

Thank you, each of you, for being here today.

I would like to ask about this business of consumers being able to make choices. We have heard a lot of testimony and at other times indicating that there is doubt that consumers have the ability to decipher all of this business and make a sound choice. What makes you believe that consumers can do that?

Mr. **McMahon**. I base my belief on the behavior in other areas, Mr. Gephardt, as well as under the experience we have with the Federal employees program. They make choices there. They have opportunities to change those choices and regularly, from their own pockets in most cases. A vast majority, both low income and high income, make a choice in favor of comprehensive coverage. There is a lot of conversation about how unique health care is. Well, automobiles are unique, too. I do not understand the internal combustion engine, but that does not prevent me from making a choice of automobiles the way I make choices across the rest of the economy.

Yes; there will be travail. There is travail in other parts of the marketplace. If we rely on the marketplace and remember individuals making choices have the protection of their employers, when they are unionized they have the protection and the interest, the dedicated interest of the unions, there is going to be lots of information out there to assist in making intelligent choices, but that is the way the marketplace runs.

Mr. BROMBERG. I would like to add to that, Mr. Gephardt, I think you have to break the population into three parts to really answer that question. The elderly, the working people, and the poor. I am not sure about the last category, but I think certainly with the working people, as Mr. McMahon pointed out, we have a lot of experience. With respect to the elderly, I would make one qualification. That is I think the Government would have the obligation to help them by providing them with information in a concise, standardized form. California employees have a system which is usually recognized as one of the best where they put out a little booklet with charts in terms of here are your five options, here are the benefits, here are the costs. That information, I think, would have to be made available to medicare beneficiaries prior to their election period for exercising that option.

Beyond that there is nothing to indicate that they couldn't make that decision.

With respect to medicaid and the poor, it may be that that decision should be made by the States since it is State money involved. One variation on your bill could be, in effect, putting all the vouchers in the hands of the State government and letting them contract with the most competitive plan. That might be one way, but I think clearly with the elderly and the working people, it would be no problem. The other basic necessities of life are food and housing. Anyone that can understand the housing market in this crazy system ought to be able to understand the difference between three and four health policies that are adequately described in an information manual.

Mr. HOFF. Mr. Gephardt, people are now making choices under the present system. They are choosing quality and they are choosing on the basis of quality. Competition interjects into it the idea that they also consider the relative cost, which I think is something that all Americans are able to judge. Competition also will give them more choice, more things to choose from. Regardless of what happens, this can only be a benefit to them. I go back to the statement made by the Commissioner of Insurance for the District of Columbia during the time of the competition between two commercial insurance companies for the business of the elderly in that case. He said it is a little bit confusing, but the important thing is that both plans being offered are better than what they had before. So, no matter which they choose, they will do better. He ended up by saying that is the benefits of competition. That was said by an insurance commissioner.

Mr. BROMBERG. I would like to add one other point. That is that the people who don't like this legislation like to confuse the issue by saying it is going to make sick people shop for doctors and hospitals while they are lying on the street. That is not at all what this bill does. As silly as it sounds, I think the record has to be set straight that we are talking about shopping for making a decision between one of a handful of insurance plans exactly as Federal employees do and then with the knowledge that during the course of that following year, you might have to pay a little more if you go to a higher priced doctor or a hospital. It may or may not be part of that insurance plan that you finally choose. We have to get away from this example that everybody gives that sick people can't make the choice of the sickness. There is nothing in your bill that would make them do that.

Mr. **Gephardt**. I was also struck by your comment when you said that it is inconsistent to say that people aren't capable of shopping but yet to say if we allow people to shop, all the well people are going to get into the same plan, adverse selection. Therefore, the whole system will fail. One of the statements has to be wrong, either the people are not going to be capable of shopping with sophistication or they are all going to get in one plan or something in between which is more likely.

Mr. **Bromberg**. The other inconsistent statement I heard was a statement by a witness that said that a voucher is really a cap and if you have a voucher you are going to have to cut services. Yet, I never heard that argument from that industry about what would happen if a cap were put on hospital income. They said in that case you wouldn't have to cut services.

Mr. **Gephardt**. Let me ask about that question. The previous panel indicated that they much preferred national health insurance or regulation through caps to hold down on the cost of health care as opposed to what is being offered here today. They cited the Canadian experience as evidence that this can be accomplished without any bad side effects. I would like your views of that approach and what is happening in Canada?

Mr. **Bromberg**. I can't give you facts right now. I will try to get them on costs. My understanding was costs were going through the roof in Canada. I can give you one practical illustration. I represent an industry of hospital management companies that manages hospitals throughout this country but many of them happen to be in the rural South and Southwest where getting physicians and nurses is a critical problem. I can tell you our greatest success in our hospital management companies has been having a recruiting office in the parent company that primarily goes to two places. London and throughout Canada to attract the doctors who want to flee the system because of the caps and controls and regulations. The same is true to a slightly lesser degree with respect to the nurses. Doctors are fleeing. Some Canadian officials are quite concerned about the reaction to what happens when you have arbitrary caps and regulations put on a profession.

Mr. **Hoff**. I can't testify firsthand but when that statement was made by the prior panel, there was a slight informal communication among the rows back in the audience and various people informed me, since they knew I was next up here, in fact, Canada may have a higher percentage of its GNP devoted to health care and perhaps a higher per capita cost. I am not sure that is relevant. There is no right answer on how much health care should be—how much of a nation's resources should be spent for health care. The last thing you want to do is get into a political game on whether health should represent 9 percent or 12 percent or some number of the GNP. The important thing to do is to turn that decision over to people and let them make it themselves, but with some economic stake in the decision. Let them select with their own money how much they want to spend.

Mr. McMahon. Mr. Gephardt, I have some Canadian hospitals in my constituency, and they don't like the Canadian system. The approach of more and more regulation does drive people away from that system, as Mr. Bromberg has indicated. The problem of an excessive regulation makes a real deterioration in the quality of patient care and also in the educational opportunities provided to young Canadian men and women for education in the medical profession.

Mr. Gephardt. Thank you very much, Mr. Chairman.

Chairman Jacobs. On the question of ability to choose among insurance programs, bearing in mind the medigap scandals of recent times, would the panel believe that that ability would vary among categories of people? For example, the aged?

Mr. McMahon. Mr. Chairman, the aged, you know, are making choices now as to supplemental coverage for medicare. Yes, it is going to vary from 65 to 75 to 85 to 95, but as long as the medicare program itself represents a fallback position, I do not see that there is going to be a great problem or permanent problem.

Chairman Jacobs. As I understand it, that fallback, that change would occur after you found out you weren't covered for this spell of illness; is that correct?

Mr. McMahon. Mr. Jacobs, if that is the problem, why don't we hear that in the Federal employees program? I don't hear—and I was involved in the administration of the Federal employees program in North Carolina some years back—I didn't hear great problems about the people who took low option and then discovered that they were head over heels in deep problems. I do think, perhaps, as people get older they may decide to go back to the fallback position; but there is the opportunity for choice. The alternative to this is to put everybody in a highly regulated mode, and——

Chairman Jacobs. I wasn't really referring to everybody, I was referring to the elderly who I take it would be somewhat more vulnerable in this regard.

Mr. McMahon. I was talking about everybody because the doctors in the hospitals are in a highly regulated mode, too. Their ability to be innovative in the development of better care at lower costs with a price consciousness is what I think we are aiming for; and obviously that is going to have some problems, but it has some problems today.

Chairman Jacobs. Speaking of that, and competition, what would be the stand of the panel on requiring hospitals to compete for medicare contracts, say, with a maximum bid system?

Mr. McMahon. We are going to get some experience in that, I take it, in the medicaid program, because as I understand it—under this reconciliation act, what you all have done——

Chairman Jacobs. You do understand it, and we congratulate you.

Mr. McMahon. I understand that part of it. I see it going on in some of the States that are beginning to look at that. Now I do not know how that is going to work, but I do think it has great advantages of experimentation and innovation. As far as the medicare program itself, rather than to do that and thus forcing choices or forcing the medicare eligibility into a system, it seems much more politically appropriate to give the individual a chance if he wants to change from what he has now to a different kind of system than to put the medicare population at the risk of a business situation.

Mr. BROMBERG. If I could change that question a little bit, Mr. Chairman, or change the answer, we have long advocated a prospective rate system under medicare which has two ingredients, one, medicare putting out a prospective rate which could be the average charge, and competitive charge or a charge arrived at after a bidding system, provided that the hospitals had the same right the doctors do now under medicare which is to charge or bill the patient over and above the difference between that rate, medicare in fact being an indemnity company, and its usual charges.

My comment would be to be consistent with competition, it would be more effective to do that than to have a high deductable which is now approaching $260 going on its way to $300, if instead we competed on the coverage, I think we would have a much better system.

Mr. HOFF. Mr. Chairman——

Chairman JACOBS. You don't accept the proposition then that Uncle Sam is a prudent shopper? If one hospital is 50 percent higher than the average of all the other hospitals in the community, then Uncle Sam just says, well, in that case, we won't shop there?

Mr. BROMBERG. I do agree with the principle. All I am saying is my little amendment to your principle would be that Uncle Sam should say we are not going to pay you because you are a higher cost hospital than what the average is.

Chairman JACOBS. The other hospital gets as much as the rest of them do and then charges the other 50 percent out of the hides of someone else? It seems to me if there is any bargaining power in the Federal Government—and maybe the responsibility for handling all this tax money that is taken out of workers' paychecks for medicare gives us that bargaining power—then that power ought to be used by the Government not to shop at places generally charging tremendous inducements of money. If we say yes, you will get just as much as the other hospital, where is the incentive to pull down the marginal amount? You just take that out of the hide of somebody else?

Mr. BROMBERG. It seems to me the only reason a patient would go to that hospital if a patient had to pay out-of-pocket there, but not all the other hospitals in town, would have to be for a very good reason or because the quality was exceptionally high.

Chairman JACOBS. Or maybe his or her doctor practices there.

Mr. BROMBERG. Which would be disclosed and made public.

Chairman JACOBS. It is really beyond the immediate choice of the patient.

Now, if that hospital were ineligible for Medicare reimbursement by reason of the, let's say, clear fact of gouging, it seems to me that the government might more nearly meet its responsibility even as the patient's doctor meets his or her responsibility.

Mr. **Bromberg**. My only problem is we have 16 years of history with the Government as the purchaser on behalf of the patient, not letting the consumer make many decisions in this area.

What has happened is that the Government has paid arbitrarily less and less and less by redefining what costs are year after year because of the Federal budget problem. If we continue along those lines and let Uncle Sam do it all for the consumer, I am afraid it is not going to work, but the hospitals are going to get sicker and sicker.

On the other hand, if we put the consumer in the driver's seat and say Uncle Sam is going to pay so much to you, to hospitals, period, to doctors, et cetera, but you will have the ultimate choice, that is a free system where people can vote with their pocketbooks.

Chairman **Jacobs**. You think the one with the doctors is working out pretty well now, where the reimbursement may be a fraction of what the actual charge is—perhaps the reimbursement itself is only the first chapter of a 10 chapter book?

Mr. **Bromberg**. Well, I am not sure that you have the same amount of competition or flexibility. I am not sure it is the same concept I am proposing. It is only similar in that one element.

Chairman **Jacobs**. Good. I appreciate that.

Mr. **McMahon**. Mr. Chairman, I think you may find it very, very difficult politically to put the Government in the position of the prudent buyer with an enforced choice because we have had some experience.

When a state government or a local government tries to eliminate an institution, whether by refusing to pay the price or whether by trying to close it, it finds that the patients that relate to that institution will support it.

It seems to me instead of doing that, as I suggested earlier, you have got to let the patient make the choice by putting a price consciousness into his decisionmaking process.

Chairman **Jacobs**. Aren't nursing homes under this system generally already?

Mr. **McMahon**. Under which system?

Chairman **Jacobs**. The system of Uncle Sam's not shopping there if the price is too high, just terminating the contract.

Mr. **McMahon**. The problem with the nursing home, it is a limited medicare benefit. Frankly, I don't have a great deal of experience in that area.

Chairman **Jacobs**. I just subscribe to the notion if you want to find out what a cowboy will do when he gets drunk, you find out what he did the last time he got drunk. I think that is an example with a lot of experience you might study up on a little bit and perhaps make further observations.

I am dead serious. It would be very helpful I think to the record.

Mr. **McMahon**. Be glad to do so.

Chairman **Jacobs**. I didn't particularly care for the regulation of Mr. Gephardt's substitute or the Carter administration's proposed hospital cost containment. It seems to me maybe we ought to take the American Hospital Association guidelines and work from there and say you won't have to be saddled with more regulation or, as you put it, more and more regulation as in Canada; you won't have any regulation at all but if you charge too much, we will just shop at the other nine hospitals in that metropolitan area.

My personal belief is that that hospital will get on the stick and make some of those innovations you are talking about and meet the guidelines.

Mr. **McMahon**. I think that is where we are headed. How can we bring an increased cost consciousness by changing incentives into the system? We will take a look at your suggestion, Mr. Chairman, and provide information to you.

Chairman **Jacobs**. We will certainly take a look at your suggestion, too.

Are there further comments from the panel?

We are very grateful to the panel.

[The following was subsequently received:]

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AMERICAN HOSPITAL ASSOCIATION
444 NORTH CAPITOL STREET, N.W., SUITE 500, WASHINGTON, D.C. 20001 TELEPHONE 202-638-1100
WASHINGTON OFFICE

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WAYS AND MEANS
HEALTH SUBCOMMITTEE

October 9, 1981

The Honorable Andrew Jacobs, Jr.
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives
1533 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Jacobs

During the American Hospital Association's testimony last week on Consumer Health Choice Plans and Competition, you asked Alex McMahon, AHA President, if he could provide the subcommittee with additional information regarding the potential effects on hospitals and Medicare beneficiaries if the Medicare program adopted a fixed-price amount of payment for hospital services. Mr. McMahon has asked me to respond to your request which I believe stems from your knowledge of several state Medicaid programs which currently pay a fixed amount for nursing home services.

It is our understanding, too, that several Medicaid plans pay for nursing home services using a pre-established fixed-price. Obviously, predetermined knowledge of nursing home rates allows those who want to participate in the program to do so and vice versa. Experience with these programs reveals both positive and negative aspects. Some operate in a manner that has stimulated growth by providing ample excess to beneficiaries while allowing providers adequate payment levels to expand needed services, at the same time providing benefits within state budgetary limits.

Other programs, however, have restricted growth, availability of nursing home beds, and have significantly reduced access to Medicaid patients. For example, the Massachusetts program has created a situation in which the number of nursing home beds has declined since providers are not being adequately paid for services. As a result, patients who normally would be transferred from hospitals to nursing homes cannot be transferred and remain in hospitals.

Unlike nursing homes, which provide basically homogeneous services, hospitals provide a variety of services to Medicare patients. Therefore, a fixed-price payment system for Medicare would have to be based on a broad range of services. This very factor has contributed to the problem of moving away from the current retrospective cost-based reimbursement system to a form of prospective system. We believe it is too simplistic to develop a single area hospital rate to pay for all types of Medicare patient services similar to the payment system for Medicaid long-term care patients, and to be able to predict the behavior of hospitals in continuing to treat Medicare patients. What we do not know are individual caseloads, and mix of individual hospital patients.

Moving Medicare payment as you suggest into a system similar to that used by Medicaid for nursing homes could bring about similar results. As you noted in your example about predicting the behavior of a drunk cowboy from his previous experiences at getting drunk, we, too, could predict that hospitals, if paid fixed-prices by Medicare, would react in one of two ways -- either continuing to provide services, if the rate were adequate; or dropping out of the program if the rate were inadequate. Nonetheless, we believe development and testing of rates is a potential area deserving further study.

AHA looks forward to working with you and the subcommittee in the future as we all try to solve our health care problems. Please do not hesitate to call upon me or Mr. McMahon for assistance.

Very truly yours,

Allen J. Manzano
Senior Vice President

Chairman JACOBS. The next panel is the Catholic Health Association of the United States, Patricia Cahill, J.D., vice president of government services; Charles D. Phillips, president of the American Protestant Hospital Association; Linda B. Miller, executive director, Volunteer Trustees of Not-For-Profit Hospitals; and Michael D. Dunn, chairman and president, Advanced Health Systems.

STATEMENT OF PATRICIA A. CAHILL, J.D., VICE PRESIDENT, GOVERNMENT SERVICES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Ms. CAHILL. Mr. Chairman, members of the subcommittee, I wish to thank you for this opportunity to present the views of the Catholic Health Association on the impact that the introduction into the health care marketplace of a greater degree of competition and consumer choice might have on the financing and delivery of health care in this country.

Catholic hospitals have had a long and distinguished record of service in the United States. More than 110 years before the Declaration of Independence was signed, a Catholic hospital was established and operating on Manhattan Island. Today, more than 650 Catholic hospitals, containing almost one-quarter of all the community hospital beds in the United States, serve our society in each of the 50 States.

Catholic hospitals are necessarily vitally interested in the strength and viability of our health care system. In terms of these hearings, that interest focuses on the effect of that system of competition and consumer choice in the health care field.

Most discussions about the high cost to today's medical care correctly identify the culprit as the structural defect in the health care marketplace. This defect has been caused by the fact that a third party payor, private insurer or Government, has been placed between the consumer and the cost of the services purchased.

There is reason to believe that the market for health care services could be made more efficient and costs thereby brought under control if that market were made more price sensitive than it is today.

Nevertheless, we are uncertain at this time at the extent to which certain of the proposed components of the competitive model, such as fixed dollar subsidies for the purchase of a health plan membership and periodic multiple choice will achieve price sensitivity. This is particularly so since a choice of services by the employee/consumer of care remains largely in the hands of his physician.

At the present time, a potential hospital patient usually chooses one of the hospitals at which his physician has staff privileges. He may choose based on geographic convenience, religious preference or the general reputation of the facility.

When ill, he rarely asks for a comparative statement from the physician of the cost differential between the hospitals, nor is it ordinarily offered by the doctor because a consideration of cost tends to run counter to the physician's concern for a sick patient.

Catholic health care facilities are concerned that the market for health care services will not become more price sensitive without stronger assurances of the link between the employee insurance purchaser and the sick employee consumer of health care services. In our opinion, that assurance depends on the wholehearted support of the medical community.

Mr. Chairman, having raised these questions concerning certain elements of the competitive model, I would now like to address myself to two specific proposals that are being considered by the Congress and/or within the administration.

The first is designed to introduce reimbursement reforms into the medicare program, the second to restructure medicare benefits with the hope or intention of yielding program savings while increasing beneficiary cost consciousness.

Catholic hospitals, in fulfilling a mission of service to the elderly and the poor, care for a very large percentage of the medicare and medicaid populations. Any substantial change in either of those programs will impact very heavily on the Catholic health care system and its patient community.

Nevertheless, in regard to the first proposal, a carefully designed and implemented program of prospective reimbursement as a means of increasing efficiency in the delivery of medical services and providing predictability to both the payor and provider of health services should be given careful consideration and evaluation by this subcommittee.

However, it should be emphasized that it is essential that no proposals for reforming hospital reimbursement be adopted that would inhibit innovations in the delivery of medical services. The long-run goal of efficiency in the delivery of medical services should not be sacrificed in the pursuit of the short-run goal of containing costs.

Equity is the issue. In order to assure that equity in reimbursement, rates must be negotiated between the provider and the Government or other payor and rates must be weighted for factors such as teaching, tertiary care, and the greater costs associated with treating some populations groups.

In regard to the second proposal, a reform of the medicare program must not result in a reduction of benefits for program beneficiaries. Nor should any structural reform result in a loss of a beneficiary's free choice of provider.

To the extent that these two prerequisites can be assured, Catholic hospitals would look favorably on experimentation within the program with a voucher system for the medicare beneficiary as long as such a system is optional for a beneficiary, not a requirement.

It should also be stated that the experience of Catholic hospitals and long-term care facilities with an elderly population warrants our expression of concern that many of the elderly are confused, even afraid of the complexity presented by today's health insurance possibilities.

The lack of assistance available to many of our aged citizens to help them comprehend viable options and the unfortunate tendency of some people to take advantage of this situation warrants the establishment of a monitoring arrangement in any voucher program which will assure that the citizens who look to Government for reasonable health protection in their aged years do not find themselves the victims of our move toward a more cost effective health services delivery system.

Additionally, the Catholic Health Assocation wishes to express concern that any competitive model or consumer choice approach to this Nation's health insurance system must include provisions for the 27 million Americans who presently have neither public nor private coverage, or who have inadequate coverage.

Our discussion of employer and employee incentives or medicare/medicaid program changes do not address the population of this country which is perhaps in greatest need, those having little or no health care coverage.

In this regard, there should be no illusions about market incentives expanding access to care; by themselves they will not. An additional Government subsidy will be required. However, once the decision has been made to provide that subsidy, market forces can be employed in order to assure that those benefits are distributed in the most efficient manner possible.

Finally, as the Congress and administration consider the introduction of competition into the health care field, it is vital that not-for-profit health care facilities have access to capital equal to the access available to other sectors of the system. Currently the greatest access is through the tax exempt bond market. We believe that market should be protected.

Mr. Chairman, the Catholic Health Association has no quick or facile remedies to the problems that this panel, the larger Congress, the administration and indeed our society face in bringing a greater degree of economic rationality, price sensitivity and equity to the health care market.

Nevertheless, we wish to assure you that our member hospitals and the staff of our association stand ready to assist you as you continue to explore this important and sensitive subject.

[The prepared statement follows:]

STATEMENT OF PATRICIA A. CAHILL, J.D., VICE PRESIDENT OF GOVERNMENT SERVICES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES

Mr. Chairman and Members of the Subcommittee: Thank you for this opportunity to present the views of the Catholic Health Association (CHA) on the impact that the introduction into the health care marketplace of a greater degree of competition and consumer choice might have on the financing and delivery of health care in this country.

Catholic hospitals have had a long and distinguished record of service in the United States. More than 110 years before the Declaration of Independence was signed a Catholic hospital was established and operating on Manhattan Island. Today, more than 650 Catholic hospitals, containing almost one-quarter of all the community hospital beds in the United States serve our society in each of the fifty states.

In 1979 the American public spent more than 45 million days in Catholic hospitals with outpatient visits totaling almost 29 million. Catholic hospitals also exert a strong positive impact on the economies of the localities they serve. In 1979, Catholic hospitals provided jobs for almost one-half million full-time equivalent employees with almost $10 billion flowing from Catholic hospitals to local wage earners and suppliers. Today Catholic hospitals are also providing a very large share of the services to the aged and poor under the Medicare and Medicaid programs as well as through the provision of care to those members of our society who are not covered by private or public insurance. Thus, as central actors in the provision of medical care to the American people, Catholic hospitals are necessarily vitally interested in the strength and viability of our health care system. In terms of these hearings, that interest focuses on the effect on that system of competition and consumer choice in the health care field.

In fact, competition already exists to a not inconsiderable degree in the health care marketplace. Over the past several years competition among providers has been increasing and it has caused hospitals to search for ways to be ever more responsive to patients' demands while, at the same time, searching for ways to become ever more efficient in the production of health services. Hospitals in a given community compete with one another for the delivery of specific services; hospitals compete increasingly with individual physicians or groups of physicians for the delivery of discrete services such as renal dialysis, ambulatory surgi-care and emergency or urgent care. Hospitals have also traditionally been considered in competition with Health Maintenance Organizations within the community, although it might be more fairly stated that fee for service physicians have been in competition with HMO doctors.

Interestingly, in this letter competitive arena, Catholic hospitals have been in the forefront of those facilities that have sponsored Health Maintenance Organizations (HMOs). Almost one-third of the hospital sponsors of HMOs are Catholic facilities with one of these actually representing more than one hospital. The California Association of Catholic Hospitals has an HMO which will ultimately encompass some 40 Catholic hospitals across the state. Competition, from the provider's perspective, is already here.

Most discussions about the high cost to today's medical care correctly identify the culprit as the structural defect in the health care marketplace. This defect has been caused by the fact that a third party payor, private insurer or government, has been placed between the consumer and the cost of the services purchased. There is reason to believe that the market for healthcare services could be made more efficient and costs thereby brought under control if that market were made more price sensitive than it is today. Nevertheless, we are uncertain at this time at the extent to which certain of the proposed components of the competitive model, such as "fixed dollar subsidies" for the purchase of a health plan membership and "periodic multiple choice" will achieve price sensitivity. This is particularly so since a choice of services by the employee/consumer of care remains largely in the hands of his physician. At the present time, a potential hospital patient usually chooses one of the hospitals at which his physician has staff privileges. He may choose based on geographic convenience, religious preference or the general reputation of the facility. When ill, he rarely asks for a comparative statement from the physician of the cost differential between the hospitals, nor is it ordinarily offered by the doctor because a consideration of cost tends to run counter to the physician's concern for a sick patient. Catholic health care facilities are concerned that the market for health care services will not become more price sensitive without stronger assurances of the link between employee insurance purchaser and the sick employee consumer of health care services. In our opinion, that assurance depends on the wholehearted support of the medical community.

Mr. Chairman, having raised these questions concerning certain elements of the competitive model, I would now like to address myself to two specific proposals that are being considered within the Administration. The first is designed to introduce reimbursement reforms into the Medicare program, the second to restructure Medicare benefits with the hope or intention of yielding program savings while increasing beneficiary cost consciousness.

Catholic hospitals, in fulfilling a mission of service to the elderly and poor, care for a very large percentage of the Medicare and Medicaid populations. Any substantial change in either of those programs will impact very heavily on the Catholic health care system and its patient community. Nevertheless, in regard to the first proposal, a carefully designed and implemented program of prospective reimbursement as a means of increasing efficiency in the delivery of medical services and providing predictability to both the payor and provider of health services should be given careful consideration and evaluation by this Subcommittee.

However, it should be emphasized that it is essential that no proposals for reforming hospital reimbursement be adopted that would inhibit innovations in the delivery of medical services. The long-run goal of efficiency in the delivery of medical services should not be sacrificed in the pursuit of the short-run goal of containing costs. Equity in the payment for the care of patients is the issue for the Catholic hospital as indeed it is for all hospitals. All too often government-designed methods of reimbursement have not used incentives to assist health facilities in becoming more efficient but have used them to reimburse hospitals inadequately for the patients they serve. This has been especially true of the Section 223 limits. When government regulations disallow reimbursement to hospitals for certain costs associated with the provision of care, they may save money in the Medicare budget but they do it by imposing an additional hidden "tax" on the private patient. When reimbursement turns out to be less than what it actually costs a hospital to treat a patient, the hospital has the choice of recouping the shortfall by charging the private patient more or, eventually, going out of business. This has been accurately labeled "taxation by regulation" and effectively puts hospitals in the role of playing Robin Hood for the government. Equity is the issue. In order to assure that equity in reimbursement, rates must be negotiated between the provider and the government or other payor and rates must be weighed for factors such as teaching, tertiary care and the greater costs associated with treating some population groups.

In regard to the second proposal, a reform of the Medicare program must not result in a reduction of benefits for program beneficiaries. Nor should any structural reform result in a loss of a beneficiary's free choice of provider. To the extent that these two prerequisites can be assured, Catholic hospitals would look favorably on experimentation within the program with a voucher system for the Medicare beneficiary as long as such a system is optional for a beneficiary, not a requirement. It should also be stated that the experience of Catholic hospitals and long-term care facilities with an elderly population warrants our expression of concern that many of the elderly are confused, even afraid of the complexity presented by today's health insurance possibilities. The lack of assistance available to many of our aged citizens to help them comprehend viable options and the unfortunate tendency of some people to take advantage of this situation warrants the establishment of a monitoring arrangement in any voucher program which will assure that the citizens who look to government for reasonable health protection in their aged years do not find themselves the victims of our move towards a more cost-effective health services delivery system.

Additionally, the Catholic Health Association wishes to express concern that any competitive model or consumer choice approach to this nation's health insurance system must include provisions for the 27 million Americans who presently have neither public nor private coverage, or who have inadequate coverage. Our discussion of employer and employee incentives or Medicare/Medicaid program changes do not address the population of this country which is perhaps in greatest need, those having little or no health care coverage. In this regard there should be no illusions about market incentives expanding access to care; by themselves they will not. An additional government subsidy will be required. However, once the decision has been made to provide that subsidy, market forces can be employed in order to assure that those benefits are distributed in the most efficient manner possible.

Finally, as the Congress and Administration consider the introduction of competition into the health care field, it is vital that not-for-profit health care facilites have access to capital equal to the access available to other sectors of the system. Currently the greatest access is through the tax-exempt bond market. We believe that market should be protected.

Mr. Chairman, the Catholic Health Association has no quick or facile remedies to the problems that this panel, the larger Congress, the Administration and indeed our society face in bringing a greater degree of economic rationality, price sensitivity and equity to the health care market. Nevertheless, we wish to assure you that our member hospitals and the staff of our Association stand ready to assist you as you continue to explore this important and sensitive subject.

STATEMENT OF CHARLES D. PHILLIPS, PRESIDENT, AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Mr. PHILLIPS. Mr. Chairman, I am Charles Phillips, president of the American Protestant Hospital Association.

It is the position of APHA that major structural changes must be made in the system by which health care services for the public are provided and financed. The current system is overregulated, a condition which is a major factor in the troublesome costs of health care. Such an environment has stiffled creativity and managerial innovativeness and initiative.

The present cost-based reimbursement system has proven to be unsatisfactory both to government and to providers. Government sees it as a blank check to hospitals while hospitals view it as a means which government has used to pay less than actual reasonable costs.

The system has frustrated sound business principles which hospitals have sought to follow whereby they can generate a surplus of income over expenses in order to assure an adequate cash flow, to accumulate the funds needed for replacement of plant and equipment and to provide working capital.

These shortfalls in reimbursement have been passed on to other payers, a condition which we consider to be blatantly inequitable and a miserably poor way of doing business.

The American Protestant Hospital Association appreciates the fact that H.R. 850 is a serous and rational proposal to bring about major reforms in the Nation's health care system. The fact that it is comprehensive in scope allows us to see where the author and sponsors of the bill want to take the system and permits the preparation of more precise comments.

Members of APHA, as would be expected, share most of the concerns which have been raised by other witnesses. However, I think it is important for members of the committee to understand a very important and unique aspect of the members of this association.

Each one is church-related and thus sees its involvement in the provision of health care as more than a social responsibility. The healing and care of the sick and injured is understood as a religious mission, just as are the missions of preaching and teaching.

Churches have invested large sums of human and financial resources in the founding and support of these institutions, which have formed a major segment of the health delivery system and which today not only provide care for the sick but also serve as health centers. The commitment to continue a ministry of healing and health through its health care facilities remains strong among churches.

I want to make clear that whatever system may emerge from the debate now beginning on appropriate reforms in health care must be one which assures equal financial opportunities for all hospitals.

Should a competitive model such as is structured in H.R. 850 or one of the other competition bills be legislated, it must be designed in such a way that the ability to compete in such a system is not impaired by the fact of ownership or classification by the IRS Code.

I want to state now briefly some of the concepts in H.R. 850 that we can certainly support.

We strongly support the replacement of a cost-based system of reimbursement. We believe it will provide improved financing, and move the not-for-profit providers to more adequate reimbursement.

It could add a real problem to the cost of health care; that is, the problem of excessive government regulation and that cost-based reimbursement. We certainly believe there is substantial need for some changes in the medicare law, and that the standardization of medicaid would be a vast improvement.

The bill makes allowance for the covering of costs for medical and paramedical education, apart from the general pricing structure for patient care. We think this is an important provision of the proposal.

We believe that it moves us in the direction of another principle that we support, and that is the uniform system of payment for all patients, eliminating much of the multitiered pricing systems of today.

We like the concept of a comprehensive coverage, approved minimum benefit plan. We certainly support the inclusion of a catastrophic coverage plan to protect individuals and families from financial disaster.

We are supportive of the requirements of the bill which would increase the sensitivity of patients and providers of the cost of health care, and believe it does provide incentive and ability to restrain undesired increases in health care costs because of this built-in incentive.

We support the development of a plan that gives individuals a choice in the method by which their health care is provided, the persons who deliver it, and the price they wish to pay.

We believe changes in tax law proposed should remove incentives to purchase overrich health plans and thus help reduce excessive demands on the system.

We believe that it gets at some of the concerns expressed by previous witnesses that there will be provision made for assistance to those who cannot purchase their own plan or who are able to purchase inadequate plans.

In stating some concerns of this bill, we certainly do not intend to put these as oppositions to the program. We believe that this debate will enable us to work at some of those concerns and bring them to points where they can be clarified, or if there are problems that are identified as a result of stating those concerns, we can work at them.

We believe this is a move in the right direction, and we certainly are willing to work with this committee in order to bring about a meeting of those concerns that we expressed.

Thank you.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN PROTESTANT HOSPITAL ASSOCIATION

Mr. Chairman, I am Charles D. Phillips, President of the American Protestant Hospital Association. With me is Bill Newbold, Director of the Office of Federal Affairs.

The American Protestant Hospital Association represents approximately 300 hospitals, homes for the aging, health care agencies, all of which are religiously sponsored, and 1600 personal members. We appreciate the opportunity to testify on the proposed National Health Care Reform Act of 1981.

It is the position of APHA that major structural changes must be made in the system by which health care services for the public are provided and financed. The current system is over-regulated, a condition which is a major factor in the troublesome costs of health care. Such an environment has stiffled creativity and managerial innovativeness and initiative.

The present cost-based reimbursement system has proven to be unsatisfactory both to government and to providers. Government sees it as a blank check to hospitals while hospitals view it as a means which government has used to pay less than actual reasonable costs. The system has frustrated sound business principles which hospitals have sought to follow whereby they can generate a surplus of income over expenses in order to assure an adequate cash flow, to accumulate the funds needed for replacement of plant and equipment and to provide working capital. These shortfalls in reimbursement have been passed on to other payers, a condition which we consider to be blatantly inequitable and a miserably poor way of doing business.

The American Protestant Hospital Association appreciates the fact that H.R. 850 is a serious and rational proposal to bring about major reforms in the nation's health care system. The fact that it is comprehensive in scope allows us to see where the author and sponsors of the bill want to take the system and permits the preparation of more precise comments.

Members of APHA, as would be expected, share most of the concerns which have been raised by other witnesses. However, I think it is important for members of the committee to understand a very important and unique aspect of the members of this association. Each one is church-related and thus sees its involvement in the provision of health care as more than a social responsibility. The healing and care of the sick and injured is understood as a religious mission—just as are the missions of preaching and teaching.

Churches have invested large sums of human and financial resources in the founding and support of these institutions which have formed a major segment of the health delivery system and which today not only provide care for the sick but also serve as health centers. The commitment to continue a ministry of healing and health through its health care facilities remains strong among churches.

I want to make clear that whatever system may emerge from the debate now beginning on appropriate reforms in health care must be one which assures equal financial opportunities for all hospitals. Should a competitive model such as is structured in H.R. 850 or one of the other competition bills be legislated, it must be designed in such a way that the ability to compete in such a system is not impaired by the fact of ownership or classification by the IRS code.

Because of the brevity of time allowed for my testimony, I am reading a summary statement. I request the privilege of submitting a more complete statement for the record. The remaining part of this statement will deal with issues and principles contained in H.R. 850 rather than providing comment on its technical components.

The proposal replaces cost-based reimbursement, a reform supported by APHA. The replacement of this system of financing health care will move the not-for-profit providers to more adequate reimbursement. The proposal gets at two of the real costs of health—excessive government regulations and cost-based reimbursement.

H.R. 850 redesigns substantially Medicare and provides an alternative for the administration of Medicaid. The position of APHA is that medical and paramedical education should be funded independently of the pricing structure for patient care. While it does not propose full coverage of educational costs, H.R. 850 recognizes the appropriateness of reimbursing independently.

This provisions of this bill move in the direction of another position held by APHA—a uniform system of payment for all patients which eliminates existing multitiered pricing systems. It provides for comprehensive coverage through an approved minimum benefit plan. APHA supports the establishment of a catastrophic coverage plan to protect individuals and families from financial disaster as a result of extended and costly medical care.

APHA is supportive of the requirements of the bill which should increase the sensitivity of patients and providers to the cost of health care and give them incentive and ability to restrain undesired increases in health care costs. APHA further supports the implementation of a health care system which gives individuals a choice in the method by which their health care is provided, the persons who deliver it, and the price they wish to pay.

The changes in the tax laws proposed in H.R. 850 should remove incentives to purchase over-rich health plans and thus help reduce excessive demands on the system. Its provision that government provide for those who are financially unable to purchase their own plan or who cannot purchase an adequate plan we support. The support of comprehensive health insurance by many provider groups was based on the need for a national program which would fill the gaps of those citizens without insurance or with inadequate coverage. Competition in health care must not work to obliterate this need.

H.R. 850 appears to be less confining than other competition bills. This may produce administrative difficulties if it is enacted with its current language regarding plan requirements, population coverage and the inclusion of Medicare beneficiaries and Medicaid recipients.

APHA supports the dismantling of the health structure required by Public Law 93-641 in favor of acceptable state and community-based planning structures, as well as the elimination of PSRO's.

Now I want to enumerate a number of concerns regarding H.R. 850. An overriding question, and one that as yet remains unanswered to the satisfaction of most hospitals, is whether health care is a commodity that can effectively be allocated by operation of free market principles. Many feel that medical care is a highly personal and emotional commodity, different from other items purchased by consumers. Persons shopping for health care for themselves or their loved ones may not shop for price.

Do the provisions of H.R. 850 in preempting state law present serious problems in the area of licensure and related legislation?

Will Americans, being the risk-averse society that we are, choose reduced access and less health care? Can the administrative demands required to meet actuarial safeguards be met and on a cost-justified basis?

Can consumer choice and competition keep in proper perspective both the demand and supply side of services? Can a competitive system devise a means of supporting the public hospitals to enable their continued existence, as well as overcome the threat to the survival of rural hospitals? If these classes of hospitals are forced to close, what assurances can be established that those who look to these facilities for their basic health care will not be denied access to basic health care? Those hospitals providing specialty care may also have concerns as to their ability to meet competitive pricing.

APHA sets out its continuing concern that any reform of the financing system assure the ability of well-managed institutions to form capital and to receive equal treatment in a return on equity. There is also some concern that hospitals could be caught in a disadvantageous position somewhere between deregulation and a consumer choice/competitive system. Congress should be aware of this potential. The field will work with this committee to identify and eliminate such dangers.

Another concern is that the implementation of a system of deductibles and coinsurance may prevent the poor and near poor and the elderly from seeking necessary care until their problems are more severe and thus result in more serious illness and more costly care or a condition which cannot be successfully managed.

Deregulation of some other industries has not resulted in cost-savings to the public. Should the infusion of consumer dollars into the purchase of health care exceed expectation and push up the cost of services purchased by government, what will the effect be? Will that which government legislated lead to a return to regulation because of the behavior of the consumer, not the provider?

APHA is concerned that the original intent of the bill be incorporated in its final language to the extent that it assures the viability of providers and does not become a mechanism for ineffectively attempting to cut federal outlays.

Since APHA also represents nursing homes, I would like to interject the caution that Congress not simply extend acute care-oriented budget and competition considerations to long-term care. The health regimen of residents of these facilities includes recreation, religion, social interaction, physical and occupational therapies and comfortable living conditions, as well as basic medical care. Competition at the level of long term-care should focus on the cost and quality of these non-health areas, as well as basic medical care, thus assuring the provision of social care.

Another question has to do with whether the goal of deregulation is achieved by H.R. 850. Some of the provisions seem to require an excessive amount of administrative detail. While providers are relieved of most regulatory burdens, will the imposition of controls on insurance carriers simply shift costs rather than reducing them?

While APHA has not reached a position on a voucher system for Medicare and Medicaid recipients, we do consider this to be an approach that should receive careful consideration by Congress. The provisions of H.R. 850 which bring Medicare and Medicaid participants into the mainstream of health care and assure providers more equitable reimbursement are desirable goals.

In conclusion, H.R. 850 has already and will continue to stimulate healthy debate and action. APHA is pleased to participate in the discussions. We appreciate the openness of members of the committee in seeking imput from health care providers. We believe that a direction has been established for a dialogue between the Congress and the health care field which will have positive results both for hospitals and the publics we serve. The climate and proposals have been established for the elimination of the excessive and counter-productive regulations on health-care providers and for the creation of a system which may lead to more adequate and appropriate reimbursement for providers.

APHA stands ready to cooperate with you in putting in place needed reforms in the health care delivery system.

STATEMENT OF LINDA B. MILLER, EXECUTIVE DIRECTOR, VOLUNTEER TRUSTEES OF NOT-FOR-PROFIT HOSPITALS

Ms. **Miller**. Mr. Chairman, I am Linda Miller, executive director of Volunteer Trustees of Not-For-Profit Hospitals. This is a new organization representing the governing boards of voluntary hospitals across the country.

On behalf of these trustees, I thank you for the opportunity to appear here today.

From the outset, let me state that the trustees of our Nation's eleemosynary institutions have traditionally been selected from among our communities' leadership. They are business men and women to whom competition is natural, attractive and familiar.

They have all excelled in a competitive business environment and bring to their banks, and to their investment firms, and to their businesses, as well as to their hospital boards, a demonstrated and spirited commitment to competition.

It is easy therefore for the trustees of the voluntary hospital sector to embrace the philosophy of competition and to espouse those goals which the sponsors of the competition bills hope to achieve—the highest quality medical care available to the most people at the lowest possible price, a change in incentives and an infusion of cost consciousness into the system.

However, a review of the bills presently before Congress causes great concern to the voluntary hospital sector and demands some words of caution. Two points particularly need notice.

First, competition and concept of open marketplace imply competition among products, not price alone. For automobiles, clothing, service contracts, airline tickets, whatever we buy, as consumers we judge the price of the product in relation to the product's perceived quality. We do not assume that the cheapest is always the best, nor do we purchase by price without evaluating what it buys.

In the health care sector, competition must translate similarly. If medicaid is still a commitment to provide good medical care to the poor of this country, then cost cannot become the sole criteria for choosing a plan.

We are dangerously close to this, and there seems to be no safeguards or disincentives to States to prohibit contracting out for services on the basis of cost alone.

In medicare this means that if we are to continue to take seriously our commitment to providing medical care to the elderly, a voucher option must constitute an enormous financial outlay by the Federal Government in order to remain reasonably equivalent to present day medicare.

This will be especially true at the outset. We cannot embrace a voucher system that is really an excuse for cutting out services and benefits to our recipients or having them ill and uninsured.

To the employed and privately insured, competition must mean being able to choose a product with an understanding of the relationship between its price and its value. Buying cheap will be most attractive when we are well, young and healthy. Who will provide the care for the underinsured, the young and sick, the hospitalized patient whose insurance has run out?

A stopgap is an expensive and necessary part, but so too, is consumer education, the underpinning of Mr. Gephardt's H.R. 850. As consumers, we are a long way from this education. I must say I think this oft-cited example of the Federal employees benefit package is an example of our lack of education. Overinsurance has contributed as much as anything to escalating health care costs.

Second, let us not take for granted a voluntary, not-for-profit hospital sector to pick up the pieces—the underinsured, the uninsured, the bad debt, the charity cases.

If we look at true marketplace competition—pick any other sector of our economy—it does not spawn a not-for-profit sector. Exxon does not write off bad debts for heating homes of the poor; GM does not donate cars to those who can't afford them.

Our hospital sector is unique in this country. The voluntary hospital is a magnificent testament to the American spirit, to that spirit of voluntarism, community responsibility, self-help and charity. It is, like nothing else in the country, a symbol and fact of our humanity, our willingness to take responsibility for our neighbors and for those less fortunate than ourselves.

We have all heard for years now, particularly from Congress and HHS, the faults in our voluntary hospitals. They have been labeled obese, rich, products of the government dole, overbedded, lacking in economies and efficiencies, and unable to define quality of care.

Some or much of it may be true, but we had better not forget—or worse, take for granted--the strength and yes, the beauty of our Nation's voluntary hospitals.

They have tapped the best instincts within us—of sharing, philanthropy and voluntarism. They have produced the finest medical care in the world. They have educated a legion of physicians in the highest tradition of medicine in the world.

They have sustained research, training, education and technological development to produce the most sophisticated science of medicine in the world. They have absorbed millions of dollars of charity care and bad debts each year and, perhaps most important, they have poured their "profits" back into breadth of service, into the hospital as a community resource. They exist by and for the communities they serve.

The point is this. The relationship between competition and a voluntary sector is not readily apparent. If competition is based on price, can a hospital remain not-for-profit, take care of its community, and compete, too?

With recent tax changes, aiding corporations and likely discouraging philanthropy, can not-for-profit institutions afford to remain not-for-profit?

Perhaps what nonprofit hospitals have been providing is really a government function, and as a nation we would prefer the government supported hospital as the provider of last resort across the board. But we had better decide, and if a voluntary sector is to continue, we need to recognize its merit and be sure we do not undermine its ability to exist.

Thank you again, Mr. Chairman. We remain willing to work with you in whatever way would be of assistance.

Mr. **Gephardt**. Thank you very much.

STATEMENT OF MICHAEL D. DUNN, CHAIRMAN AND PRESIDENT, ADVANCED HEALTH SYSTEMS, INC.

Mr. **Dunn**. Mr. Chairman, my name is Mike Dunn. I would like to thank you for the opportunity to participate in this hearing.

In the interest of time, I ask that my entire written statement be included in the record. I will briefly summarize it for the subcommittee.

Suffice it to say that as the chief executive officer of Advanced Health Systems, which is the Nation's sixth largest investor-owned hospital organization, I have had some experience in health care delivery and health economics from our 52 hospitals.

These hospitals include the 20 Raleigh Hills hospitals for alcoholism treatment, which is the single largest private inpatient provider of alcoholism treatment services in the Nation.

Irrespective of the actions that may be taken by the Federal Government to improve the cost effectiveness of the medicare program, I am pleased to report that market forces are beginning to create areas of competition and price consciousness within the health care field.

Although competition is certainly no panacea, it is far superior to the existing system, which is damaged by well-meaning but unrealistic efforts to regulate cost through cost reimbursment and restrictions on supply.

The existing approach can only decrease access to the poor and aged while it encourages waste of taxpayer funds.

If the Federal Government wants to improve the system, it should immediately eliminate cost reimbursement, concentrate on limiting taxpayer expenditures and protecting access for the beneficiary, and move immediately to something like percent of changes reimbursement.

If the Federal Government needs a discount of say 12 or 14 percent from charges to match the actual expenditures with congressional appropriations, it should mandate it by offering to pay hospitals that percentage of their charges. They should stipulate, however, that if aggregate medicare claims rise faster than the level of congressional authorizations due to either change in price and/or utilization, that the percentage of charges being reimbursed, be adjusted downward on a short interval basis to assure that medicare expenditures do not exceed congressional appropriations.

I would encourage this subcommittee to resist all well-meaning efforts to control charges by measuring providers against areawide averages or other similar approaches. Those efforts frequently do not control anything but, instead, frequently stifle innovation and encourage gamesmanship amongst different providers in a given area.

If we want competition, let us encourage price awareness and flexibility and not a new method of pretending that we may control medicare expenditures through unnecessary regulation and, at all costs, avoid a new Accountant's Full Employment Act of 1982.

As I have stated in my written testimony, a medicare voucher system will not reach its real value until the cost reimbursement psychology and other negative aspects of the existing system are fully eliminated.

Will this system work? Yes, it will work better than the other alternatives. Positive innovation to save cost is possible in a competitive environment. In fact, I have felt compelled to back up my opinion with a very specific proposal in our area of expertise, in the area of medicare reimbursement for alcoholism, where such a flexible approach to coverage and reimbursement would not only save the taxpayers more than $1 billion annually, but would substantially improve the health and well-being of the elderly and disabled medicare beneficiaries by significantly improving their opportunity for rehabilitation.

The current cost reimbursement system provides virtually 100 percent coverage—with some deductibles—for medicare beneficiaries to have alcoholism treated in the most expensive, acute, inpatient settings, such as our own Raleigh Hills hospitals, and provides virtually no coverage for vitally needed and lower cost outpatient and after-care services.

Also, the provider and the patient under the current system have no financial stake in achieving the desired outcome, which is obtaining and maintaining sobriety for the patient. In the disease process of alcoholism, that of course is patently ridiculous.

In our widely supported proposal, we urge the Congress to reduce medicare coverage to 75 percent of charges, which is a figure well below the provider's cost of providing the service.

It also proposes to eliminate cost reimbursement, extend the coverage to allow flexible substitution of lower cost outpatient and after-care services and require that the patient be responsible for the balance of the charges.

To assure proper safeguard for the disabled and elderly, the provider would be required to admit all medicare patients, including the indigent, and to not use collection agency techniques or be allowed to bill medicaid or welfare funds.

Thus, the provider would have to rehabilitate the patient to insure collection of much of the balance. Prosperity and survival would be tied to actually delivering the results.

I remind this subcommittee that the average medical alcoholic consumes at least $2,000 to $3,000 a year worth of alcoholic beverages. Thus, sobriety does provide an opportunity for payment. Frankly, our experience is we have never had a bad debt from a sober patient.

About one-half of the $1 billion in annual savings available under this type of change would come from direct lowering of medicare payments to hospitals in general, and the rest of the savings from less retreatment and lower cost outpatient treatment.

In total, this is not only an opportunity to eliminate a wasteful expenditure of $1 billion annually. It also is an opportunity to actually improve the lives of the hundreds of thousands of medicare recipients treated for the disease of alcoholism each year.

In conclusion, I would urge the immediate adoption of this type of approach in the major area of alcoholism treatment, the subsequent use of this approach as a model in evaluating the merits of percent of charges reimbursement in general, and your consideration of the need to eliminate the basic problem, which virtually everyone here today has agreed is artificial control and regulatory programs such as cost reimbursement.

If you do these things, I suggest that we will surely see increased price competition, which will eventually be enhanced by a medicare voucher system, similar to those being considered by this subcommittee.

Thank you for the opportunity to appear before you today. I would be delighted to answer any questions either you, Mr. Chairman, or any of your distinguished colleagues or staff may have.

[The prepared statement follows. Additional material has been retained in the subcommittee's files.]

STATEMENT OF MICHAEL D. DUNN, CHAIRMAN AND PRESIDENT OF ADVANCED HEALTH SYSTEMS, INC., IRVINE, CALIF.

Chairman Jacobs, Members of the Subcommittee:

It is a pleasure for me to be able to testify before this distinguished Subcommittee on a subject of great interest to Advanced Health Systems, Inc. -- competition in the health care sector. I sincerely appreciate the opportunity which you, Mr. Chairman, the Members of your Subcommitte, and your competent and helpful staff have afforded us in allowing us this expression of our views before Congress. Accompanying me this morning at the witness table is our counsel, Frederick H. Graefe, Esquire, of the Washington law firm of Perito, Duerk, Carlson & Pinco, P.C. Our purpose in appearing here today is to share with you a proposal we have developed for bringing competition into the health care sector and at the same time reducing the costs to government of the Medicare program.

Advanced Health Systems, Inc. (AHS), is a subsidiary of Petrolane, Inc., with its corporate offices located in Irvine, California. I am the President and Chairman of the Board of AHS.

AHS is one of the leading providers in this Nation's health care delivery system. It currently either owns or operates over 50 hospitals and some 250 other facilities, primarily in the western United States. One of the aspects of the AHS delivery system is Raleigh Hills Hospitals, which own and operate 20 short-term, acute care hospitals, specializing in the treatment of alcoholism. Since its first hospital was opened in 1942 the name Raleigh Hills has been continuously associated with quality care.

As the leader in the field of alcoholism treatment, Raleigh Hills Hospitals conduct continuous research and education as a means of maintaining a leadership role as well as assisting other alcoholism treatment providers in order to improve the entire field.

The AHS Health Care Technology Group provides management, technical and ancillary services to other health care providers as well as to the AHS operated facilities. The professional expertise available through AHS' services include facilities management, manpower management, patient services improvements, information systems, financial management, health care planning, and shared services development and operation. The shared services provided by AHS medical centers and pharmacies, medical supplies and purchasing, forms, billing systems and princing, and all the health care services.

The AHS Managed Facilities Group provides total management and operation of primary health care systems in rural communities. The AHS managed health care systems include small hospitals, nursing homes, medical clincs and specialized facilities. Through the utilization of AHS' broad spectrum of resources and expertise, AHS managed facilities are able to provide appropriate, stable, high quality primary health care to each of these rural communities.

AHS strongly supports the institution of a competitive voucher system in the Nation's health care system. (A complete company profile is attached as an appendix.) Health expenditures have grown from 1965 to 1979 at an annual rate of 12.3 percent. This figure is in excess of the annual growth in GNP and needs somehow to be curtailed. The regulatory efforts that have thus far been tried have not been successful. Thus, it is time to try a new approach. By stimulating competition in the health care sector and at the same time by increasing cost-awareness by consumers, there should be a moderation in the current inflationary, expansionist pressures on the system and an improvement in access to and quality of health care. The objective here is to provide the best care of the lowest price.

In addition, a side benefit will be a decrease in utilization of medical services. Since the institution of entitlement programs and a growth in the use of private third party payors, there has been a large increase in utilization. The present system offers no incentive to the consumer or provider to decrease utilization. It has been shown in prepaid group practices that even a small copayment will act as a deterrent to overutilization. Recently, the Rand Corporation again demonstrated this principle in a health insurance experiment. It found that cost sharing does affect utilization. I will discuss this further when I address our proposed percent of charges method of Medicare reimbursement for the treatment of alcoholism.

As I have already stated, the institution of a competitive voucher system in the Nation's health care system is strongly supported by Advanced Health Systems. Before this type of approach can be implemented, however, several preparatory steps must be taken.

First, in moving toward health care reform the total and immediate elimination of cost reimbursement should be effected. To accomplish this, the Federal Government should change Medicare reimbursement so that it is based on percent of charges. In addition, states would be granted the flexibility to choose any method of reimbursement for Medicaid other than cost reimbursement. The percentage of charges reimbursed would be established based upon actual experience from the cost reimbursement system and would apply equally to all providers regardless of their previous history of costs and charges. For example, if the current cost reimbursement system is resulting in reimbursement at approximately 88% of charges, then the Government would simply reimburse 88% of hospital charges.

The Congress should stipulate, however, that if aggregate Medicare claims rise faster than any level of expenditures it has chosen to authorize, the percent of charges being reimbursed will be adjusted downward, on a short interval basis, to assure that expenditures and commitments of the Department of Health and Human Services do not exceed the Congressional appropriations. Thus, the percent of charges reimbursement would be capped in the aggregate to assure that price changes, volume changes, or shifts in utilization patterns cannot possibly cause the taxpayer to bear the greater level of expense than the Congress has authorized. Accordingly, the Government will have assured the guaranteed cost to the taxpayer with minimal administrative expense to both the Government and the health care provider. In so doing, the Government will be encouraging innovation, efficiency and flexibility on the part of health care providers.

Should the percent of charges approach (with the aggregate expenditure limitation to protect the taxpayer) be infeasible to implement, an alternate, but less popular, choice would be to reimburse hospitals on a predetermined rate per admission. On that basis, hospitals would simply be reimbursed 88% of their most recent average revenues per admission, periodically adjusted for inflation. Most importantly, the most recent revenue per admission would have absolutely nothing to do with cost reports of any kind. (The 88% of revenue holds whether it is cost per unit, cost per admission or cost per day.) Thus, subject to the Government's right to review, each hospital would file a statement indicating its average revenue per admission in the six months preceding the effective date of the new program. The fiscal intermediary would audit such reports and make retroactive adjustments if it finds error or omissions. Those immediate preceding six months would then be used as a starting point for any revenue per admission reimbursement program. Again, all cost reports and administrative expense associated with their issuance and auditing by providers and the Government would be eliminated. The Government would have the ability to guarantee the taxpayer's expense, except that it would have no real control over the number of admissions. Although this system would be superior to the current cost reimbursement approach, there is certainly a greater possibility of manipulation than in a "percent of charges" reimbursement approach.

Approximately 18 months after the complete phaseout of the cost reimbursement approach, the second step should be implemented. This involves the repeal of the Federal Certificate of Need legislation. A major barrier to the development of competitive forces in the health care sector would thus be removed. There would be an increased freedom of market entry for competitors as well as increased flexibility of existing institutions to adjust their services to market conditions.

This, in addition to a program that does not reimburse on a cost basis, would encourage competitors to adjust services and facilities based upon real market opportunities. Furthermore, the general public would eventually become more price conscious.

The final phase in our health care proposal would be the implementation of an optional Medicare voucher system. Current Medicare beneficiares would have a choice of remaining in the present program or opting for a private insurance plan; newly eligible Medicare beneficiaries would be required to obtain coverage from a private plan. This plan hopefully would serve as a bridge to the eventual implementation of an all-inclusive voucher program at some point in the near future. Such a system would make bureaucratic institutions such as PSROs superfluous since each plan would privately review plan utilization.

In implementing a voucher system the Federal Government first must establish the criteria for a minimally acceptable health plan; for example, a private plan should include present Medicare and catastrophic coverage. Such a plan would define the coverage level that must be met for a plan to be approved for the voucher system. Individual Medicare recipients would have the choice of spending the entire voucher, more than the entire voucher, or less than the entire voucher. The only restriction would be that the voucher must be spent for a plan that meets the minimal Federal standards. If a Medicare recipient selects a plan that costs more than the voucher, he must make up the differnce. The value of a voucher would be determined actuarially.

Similary, employers and unions, for example, could provide any type of health plan through collective bargaining or individual decision; however, all health plans over a given annual cost would be taxable as ordinary income to the employee and all health plans provided would have to be at least equal to the Federal minimum standards. Self-employed individuals would be allowed to take tax deductions for participation in health plans up to the cost limit of those plans that are tax free benefits for other individuals or they may deduct itemized medical expenses up the the level of the tax deduction allowed for participation in health plans. All expenditures above that level would not be deductible.

Qualifying health plans could be organized as prepaid plans, service plans, indemnity insurance plans, combination of indemnity and prepayment or any other innovations of the free enterprise system as long as they meet the minimum Federal standards. The Department of Justice would need to vigorously enforce the Federal anti-trust laws to prevent provider-carrier consortiums from restraining trade through their health plans in certain geographic areas. For example, a health plan that contracts with any hospital must offer all hospitals the same terms and conditions for participation in that health plan. Similarly, a health plan that agrees to contract with a physician must agree to offer those same terms and conditions to all qualified physicians in that region. The qualification of doctors and hospitals would be based upon the issuance of licenses to practice medicine and operate hospitals by each state, not by arbitrary restrictions.

To illustrate how competition would work in the market place, I will now turn to describe the AHS proposal for a percent of charges method of Medicare reimbursement for alcoholism treatment. This concrete proposal is ready for immediate implementation, and will result in improved patient outcome and a Federal budget savings in the second full year of over $1 billion. This proposal, however, is not so narrow that it cannot be generalized to a broader range of medical treatments.

In essence, we feel that Medicare should get out of the business of deciding what to reimburse and stick to the business of deciding how much to reimburse. (A more complete description of this reimbursement plan -- and an evaluation of its $1 billion savings -- is attached as an appendix.)

Under the current system of allowable cost reimbursement there are perverse incentives that work on the provider. At present providers are rewarded for placing a patient in the hospital where reimbursement through Medicare is possible as opposed to administering to the patient on an outpatient basis at a lesser cost. To contain costs and deliver effective treatment, the provider's mercenary and beneficent motives need to be channeled toward the same goal; in the case of alcoholism, the patient's long-term sobriety.

We recommend that Medicare reimburse a flat 75 percent of charges, which is a percentage well below what has been reimbursed by the Health Care Financing Administration (HCFA) in our facilities over the past three years. According to the Federation of American Hospitals, the current cost reimbursement system is resulting in reimbursement at approximately 88% of charges. By reimbursing on a percent of charges basis, the Government and provider decide "up front" what coverage a Medicare beneficary can expect, thus taking third and fourth beneficiary parties out of the process of choosing treatment for an individual beneficiary. When incentives are changed to encourage cost-efficient procedures, energies are redirected successfully toward a new goal; positive incentives can directly influence decisions made by millions of individuals working toward personal goals.

By setting positive incentives for cost-efficient health, the Government can sit back and wait for the results, wait for what Charles Schultz has called: "the public use of private interests."

We further propose that the patient be held accountable for the remaining 25 percent and that no other source of public money be available to either provider or patient for this 25 percent of charges. This guarantees that the patient is the only source for these charges and motivates the provider to achieve sobriety for the patient -- a recovered alcoholic pays his or her bill and speaks well of the treatment program. Furthermore, the patient who has invested in his or her treatment is better motivated to get something out of it. Consistent with this idea, we have found that Medicare beneficiaries were the worst performers at achieving long-term sobriety in three years studied at our Fair Oaks, California hospital. Twenty-five percent-of-charges is a large enough portion for both the patient and provider to take the debt seriously, and for the provider to keep costs of treatment down to reduce the loss by bad debt.

It should be made clear, however, that no individual will be denied treatment due to inability to pay.

Allow me to expand further on the issue of inpatient versus outpatient care. At present Medicare coverage is limited to inpatient varieties of treatment. In the case of alcoholism, Medicare patients, are sometimes the best candidates for outpatient treatment, as it provides long-term social supports that may be necessary to their recovery. Even though it might be a more effective form of treatment, and even though it is less costly, providers cannot offer it because it is not a covered benefit by Medicare.

Reimbursement by a flat percent of charges permits the provider to design treatment and price to meet the patient's detailed needs. For the elderly and disabled, it is cruel to return them again and again to an expensive and possibly unsuitable form of treatment.

To recapitulate, for the incentives in our proposal to work toward cost-containment and patient recovery, the following six conditions are essential:

(1) That Medicare reimburse a flat 75 percent of charges, not costs. The savings in administrative costs that could be realized by switching to this simple predictable system, taking into account our own and government's layers of administrative costs, is probably quite substantial. The immediate savings, within the first year, directly realized by a reduction in the rate of reimbursement is nearly $500 million annually.

The important element to remember is that the percent of charges level of reimbursement -- whether higher or lower than 75 percent -- must be below the provider's cost basis, thus ensuring the provider's interest in a favorable patient outcome and the patient's balance of payment.

(2) That the Medicare patient be held accountable for the remaining 25 percent of charges, thereby guaranteeing that the provider either achieves sobriety for the patient or stands to lose the 25 percent of its charges. The money that an alcoholic does not spend on liquor -- estimated to be $2,000-$3,000 annually -- is "new" money and would easily cover the 25 percent of charges for successfully treating the disease, without having an impact on the patient's ability to have the necessities of food, clothing and shelter. Substantial safeguards would be included to prevent legal or other collection techniques. Collection from the patient would, then, depend on his or her sobriety. Additionally, the patient's 25 percent could not be paid by Medicaid or any other public source.

(3) That no patient be refused treatment because of inability to pay. This condition preserves the entitlement of services while putting pressure on the provider to find better, more cost-effective

methods of treatment. The treatment needs to be better in order to cure the most difficult case, and the treatment needs to be cost-effective should the treatment fail. We project that the improved treatment outcomes and methods will result in an additional savings of over $500 million annually.

(4) That the reimbursement procedure in no way depend on the type of service provided to the patient. This makes all types of treatment equally affordable by patient and provider, leaving them free to select the best for the individual case. It also encourages successful treatment of alcoholism directly, by offering this freedom to providers, in order to reduce the serious illnesses associated with alcoholism that contribute subtantially to the Nation's overall health care costs and that Medicare pays for inevitably.

(5) Although we believe that the marketplace is adequate to control any tendency to abnormal charges by providers, since both Medicare and non-Medicare patients would be charged from the same schedule, the Government could consider recognizing only those charges whose rate of change does not exceed an established index, for example, the Consumer Price Index (CPI).

(6) That there should be no attempt to compare itemized charges for providers in order to discourage "gaming" which is the normal response to all efforts of the Medicare program to impose comparative or area-wide ceilings.

AHS strongly believes that this proposal merits legislative action. The incentives inherent in the percent-of-charges reimbursement system are natural for the cost-efficient and effective treatment of Medicare alcoholics. The medical importance of alcoholism as the number three killer in the United States, and the economic importance of alcoholism as a major drain on our society's wealth through lost productivity and increases in associated illness, both argue for serious consideration of our plan for "public use of the private sector." Our proposal for natural, positive cost-containment incentives has logic and common sense to support it. AHS urges its legislative implementation.

In closing, I would like to say that these hearings are a step in the right direction with respect to controlling health care costs. By bringing competition into the health care sector consumers will be able to obtain high quality care at a lesser cost. I cannot, however, overemphasize the need to phase in the voucher system by first eliminating cost reimbursement and repealing the Certificate of Need legislation.

To summarize, our proposal, when enacted, would significantly improve patient outcome, which is, of course, the desired effect of the Medicare program. Secondly, the AHS proposal will result in Federal budget savings of over $1 billion in the second full year of implementation. While this proposal is not a panacea for all of the ills of the Medicare program, it is clearly superior to the present system of cost reimbursement and will improve the wellness of the Medicare beneficiary. Accordingly, our proposal, we submit, should be seriously and thoughtfully considered now -- and independently of any Medicare voucher plan, which we urge as a more long-term solution for Medicare.

Thank you for the opportunity of being able to present our proposal to you this morning. We would be delighted to answer any questions you might have.

AHS
ADVANCED HEALTH SYSTEMS, INC
A PETROLANE COMPANY
17861 CARTWRIGHT ROAD • IRVINE, CALIFORNIA 92714 • (714) 641-1616

The Honorable Dan Rostenkowski
U. S. House of Representatives
Washington, D.C. 20515

September 22, 1981

Dear Mr. Chairman:

Advanced Health Systems, Inc. (a subsidiary of Petrolane, Inc.), is a private provider of alcoholism treatment and other health care services. We are proposing a change in Medicare's coverage and reimbursement for alcoholism treatment that will improve the client's chance of recovery and could well save the government over a billion dollars annually in its second year of operation.

The present system limits the treatment available to the Medicare alcoholic -- not all forms of treatment are covered -- and, by reimbursing for "costs," it encourages unnecessary expense. As an illustration: although we strongly believe that some elderly and disabled alcoholics need, in order to recover, the long-term social supports afforded by lower cost outpatient treatment, only higher cost inpatient services are covered.

Rather than individually correct each perverse incentive as discovered in the present system, we propose to turn the system around to one of positive fiscal incentives for achieving sobriety for the client at lower cost to the taxpayer through a system that reimburses a percent of charges, leaving the provider and client free to choose the most cost-effective treatment.

Our proposal is described in the Executive Summary following and is elaborated further in appended material. With logic and commonsense to support this plan whereby natural incentives work to the benefit of client, provider, and government, we strongly believe that legislative action is the appropriate mechanism for the change.

You understand, we are sure, the need for every citizen to be regarded as a potentially responsible human being capable of overcoming misfortune, including the ravages of alcoholism. The dignity of contributing to one's own recovery from alcoholism while helping to reduce government spending is a realistic and positive plan for helping the nation's elderly and disabled.

Very truly yours,

Michael D. Dunn

Michael D. Dunn
ADVANCED HEALTH SYSTEMS, Inc.

HEALTH SERVICES
• Raleigh Hills Hospitals
• Professional Practices
• Advanced Health Centers

MANAGED FACILITIES
• Inpatient Services
• Outpatient Services
• Specialized Services

HEALTH CARE TECHNOLOGY
• Management Services
• Technical Services
• Ancillary Services

EXECUTIVE SUMMARY

ADVANCED HEALTH SYSTEMS, INC., the nation's largest private provider of alcoholism treatment services, sees an opportunity for the government to save over a billion dollars a year[1] while achieving public good.

Through improved benefits under the Medicare program's coverage for alcoholism treatment, Medicare can continue its leadership in recognizing the need to treat what has been named the nation's number-three killer after heart disease and cancer.

Like other providers of health care services, we have experienced problems in delivering what we regard as the best service to Medicare clients under the current coverage for in-hospital treatment only, and under the system of reimbursing for "costs." We are constrained to deliver in-hospital treatment whether or not we feel it is the best choice for an elderly or disabled client needing long-term social supports of the kind possible in outpatient programs. Furthermore, in-hospital treatment is more expensive than what we may sometimes feel is the best treatment.

Under the current system, any Medicare provider of alcoholism treatment is financially constrained to supply the elderly and disabled with what could prove to be revolving door in-hospital treatment, even though the provider has a better idea. The reimbursement system not only makes treatment decisions, but from a great distance. The effect on treatment is, therefore, not always appropriate and sometimes quite harmful.

We are not the first to complain about the perverse incentives that work on the provider under "allowable cost reimbursement," nor are we the only ones to propose a solution. We may be the only ones, however, to offer a simple solution that takes into account the self interest of provider and client. To contain costs and deliver effective treatment, the provider's mercenary and beneficent motives need to be channeled toward the same goal: the client's long-term sobriety.

We propose that Medicare get out of the business of deciding what to reimburse and stick to the business of deciding how much to reimburse. We recommend that Medicare reimburse a flat 75 percent of charges, which is a percentage well below what has been reimbursed in our facilities over the past three years. Done this way, the government and provider decide "up front" what coverage a Medicare beneficiary can expect, thus taking third and fourth parties out of the process of choosing treatment for an individual beneficiary.

We further propose that the client be held accountable for the remaining 25 percent and that no other source of public money be available to either provider or client for this 25 percent of charges. This quarantees that the client is the only source for these charges and motivates the provider to achieve sobriety for the client — a recovered alcoholic pays his or her bills and speaks well of the treatment program. Furthermore, the client who has invested in his or her treatment is better motivated to get something out of it.

For the incentives in our proposal to work toward cost-containment and client recovery, four conditions are essential:

1. Medicare reimburse a flat 75 percent of charges, not costs. The savings in administrative costs that could be realized by switching to this simple and predictable system, taking into account our own and government's layers of administrative costs, is probably quite substantial. The immediate savings, within the first year, directly realized by a reduction in the rate of reimbursement in our twenty facilities alone would be tens of millions annually.
2. The Medicare client be held accountable for the remaining 25 percent of charges, thereby guaranteeing that the provider takes good care of his client, since the provider either achieves sobriety for the client or stands to lose 25 percent on charges. The money that a recovered alcoholic does not spend on liquor is "new" money and would easily cover 25 percent of charges for successfully treating the disease, without impacting the client's ability to have the necessities of food, clothing, and shelter.
3. That no client be refused treatment because of inability to pay. This condition preserves the entitlement to services while putting pressure on the provider to find better, more cost-effective methods of treatment. The treatment needs to be better in order to cure the most difficult case, and the treatment needs to be cost-efficient should the treatment fail.
4. That the reimbursement procedure in no way depend on the type of service provided to the client. This makes all types of treatment equally affordable by client and provider, leaving them free to select the best treatment for the individual case. It is as well to encourage successful treatment of alcoholism directly, by offering this freedom to providers, in order to reduce the serious illnesses associated with alcoholism that contribute substantially to the nation's overall health care costs and that Medicare pays for inevitably.

ADVANCED HEALTH SYSTEMS, INC., strongly believes that the proposal merits legislative action. The incentives inherent in the "percent-of-charges" reimbursement system are natural for cost-efficient and effective treatment of Medicare alcoholics. The medical importance of alcoholism as the number three killer — after heart disease and cancer — in the United States, and the economic importance of alcoholism as a major drain on our society's wealth through lost productivity and increases in associated illness, both argue for serious consideration of our plan for "public use of the private sector."

Should we fail to argue convincingly enough for our proposal to achieve legislative action, we are prepared to demonstrate the power of these natural incentives on ourselves. We have prepared a proposal, which is appended, to the Health Care Financing Administration to show that "percent-of-charges reimbursement" in our twenty specialty hospitals in nine states will improve the recovery rate among our Medicare clients and will save government tens of millions of dollars, in our facilities alone. We can estimate from our results the impact of implementing the plan nationally.

Although a demonstration of our proposal before considering it for legislative action may seem the safest way to proceed, we feel it is not the wisest. Our proposal for natural positive cost-containment incentives has logic and commonsense to support it. We urge its legislative implementation.

[1] These savings are based on the following items that are explained more fully in Chapter II:

A.	Immediate drop in the percent paid on charges from current levels to 75%	$488,199,000
B.	Immediate drop in our visible administrative costs for cost-reimbursement. This does not include whatever administrative costs might be saved at the relevant layers of government.	6,115,000
C.	Savings after a year from reduced numbers of retreated clients, savings resulting from the provider's incentive and freedom to choose the most effective treatment.	300,430,000

D. Savings from the reduced cost of treatment once provider is free to choose the best mix of in-hospital and outpatient services.	225,322,000
E. Savings from illnesses not incurred by recovered alcoholics. We feel a dollar estimate of this savings is not possible at this time, but are aware that current estimates give substantial importance to alcoholism as a hidden source of major illness.	???
TOTAL: (without E.)	$1,020,066,000

Please note that A. and B., which come to nearly half a billion dollars, are saved immediately. C. and D. may take up to a year to achieve. Thus, first year savings will certainly exceed $500,000,000 and annual savings, thereafter, will certainly exceed $1,000,000,000.

AHS
ADVANCED HEALTH SYSTEMS, INC.
A PETROLANE COMPANY
17861 CARTWRIGHT ROAD • IRVINE, CALIFORNIA 92714 • (714) 641-1616

ADVANCED HEALTH SYSTEMS, INC.

COMPANY PROFILE - OCTOBER, 1981

Advanced Health Systems, Inc., has been a subsidiary of Petrolane, Inc. (NYSE) since 1969. The roots of Advanced Health Systems, its predecessor companies, and its divisions date back to 1929. Corporate offices are located in Irvine, California.

Advanced Health Systems is a multidisciplinary, specialized health care provider, management and service company. Advanced Health Systems' activities are organized into three major operating groups. The following describes the basic responsibilities of each of those groups:

HEALTH SERVICES

The Health Services Group consists of three significant functioning units supported through its Irvine, California, and Kansas City, Missouri Division Offices. The first of these units is our Raleigh Hills Hospital Division. Raleigh Hills owns and operates twenty short-term, acute urban hospitals, specializing in both the inpatient and outpatient treatment of alcoholism as well as primary medical care. These twenty hospitals are located in the following cities:

Portland, Oregon (1942)
Spokane, Washington (1971)
Newport Beach, California (1971)
Redwood City, California (1972)
Sacramento, California (1974)
Salt Lake City, Utah (1975)
Las Vegas, Nevada (1975)
Denver, Colorado (1975)
Oxnard, California (1976)
Dallas, Texas (1979)
Glendale, California (1979)
Houston, Texas (1979)
Bellflower, California (1979)
San Fernando Valley, CA (1980)
Miami, Oklahoma (1980)
San Diego, California (1980)
St. Louis County, MO (1981)
San Gabriel, California (1981)
San Antonio, Texas (1981)
Reno, Nevada (1981)

In addition to the twenty Raleigh Hills Hospitals listed above, additional facilities are under construction or development in the following communities:

Boise, Idaho (1982)
Jefferson City, Missouri (1982)
Gresham, Oregon (1982)
Eugene, Oregon (1982)

Beyond the operation of the 24 existing or developmental Raleigh Hills Hospitals, the Raleigh Hills Hospital Division provides national leadership in alcoholism, research, and education, both directly and through its association with the Raleigh Hills Foundation.

The second function of the Health Services Group addresses the sponsorship and management of family practice and other medical and behavioral medical outpatient clinics. These professional organizations provide, in association with private practitioners, family and behavioral medical programs in cities where the Raleigh Hills Hospitals are located. In many of these locations, these professional practices provide the public with traditional family medical services, as well as mechanisms for altering behavioral disorders such as alcoholism, obesity, smoking, and hypertension.

The third function of the Health Services Group is the Advanced Health Center in Newport Beach, California. The Center is dedicated to upgrading public health status through primary health services, life style change, and resultant health improvement and maintenance.

HEALTH CARE TECHNOLOGY

The primary responsibility of the Health Care Technology Group is to provide Advanced Health Systems' management, technical, and ancillary services to other health care providers throughout the country. These services have been delivered to more than seven-hundred health care facilities and organizations throughout the United States, Western Europe, and Australia. Similar supportive services are also supplied nation-wide to several thousand physicians, dentists, and psychologists. The professional expertise available through Advanced Health Systems' services includes the management of hospitals, clinics, and other health care institutions, consulting and contract services in all areas of health care management, the development and operation of shared services, and the implementation of patient care programs. The shared services provided by Advanced Health Systems include medical center pharmacies, medical supply and purchasing, billing systems and printing, and home health care services.

The Health Care Technology Group maintains permanent offices in St. Louis, Missouri; Saginaw, Michigan; Salt Lake City, Utah; Denver, Colorado; and Irvine, California, regionally supporting its clients throughout the country.

Long term ancillary services locations and health care facilities affiliated with, or managed by, the Management Services Divisions are located in the following communities:

ANCILLARY SERVICES

Salt Lake City, Utah (1929)
Denver, Colorado (1955)
Los Angeles County, CA (1979)
Boise, Idaho (1981)
Coalville, Utah (1981)
San Antonio, Texas (1981)

MANAGEMENT SERVICES

St. Louis, Missouri (1968)
Saginaw, Michigan (1973)
Los Angeles County, CA (1979)
Orange County, CA (1979)
Riverside County, CA (1980)
Ventura County, CA (1980)
Salt Lake City, Utah (1980)
Houston, Texas (1980)
Cedar Vale, Kansas (1981)
Broken Arrow, Oklahoma (1981)
Hawthorne, California (1981)
Denver, Colorado (1981)

MANAGED FACILITIES

The Managed Facilities Group, headquartered in Salt Lake City, Utah, is organized to provide total management and operation of primary health care systems in small communities and rural areas. These systems may include small hospitals, nursing homes, medical clinics, and specialized facilities. The Managed Facilities Group, on behalf of each local community it serves, manages and operates these health care systems, addressing the individual needs of those communities. Through the utilization of Advanced Health Systems' broad spectrum of resources and expertise, the Managed Facilities Group provides appropriate, stable, and high quality primary health care to each of these communities.

As of October, 1981, the Managed Facilities Group manages and operates twenty-three health care systems, as follows:

MIDWEST DIVISION

Crook County, Wyoming (1978)
Buchanan, Michigan (1979)
Beach, North Dakota (1979)
Oswego, Kansas (1979)
Custer, South Dakota (1979)
Webb City, Missouri (1980)
Taos, New Mexico (1980)
Dade County, Missouri (1980)
Muskegon Heights, MI (1980)
Santa Rosa, New Mexico (1980)
Martin, South Dakota (1981)
Philip, South Dakota (1981)
Marlow, Oklahoma (1981)

WESTERN DIVISION

Evanston, Wyoming (1978)
Kane County, Utah (1979)
Summit County, Utah (1979)
Tooele County, Utah (1980)
Grand County, Utah (1980)
Nye County, Nevada (1980)
Power County, Idaho (1980)
Townsend, Montana (1980)
Holbrook, Arizona (1981)
Fallon, Nevada (1981)

These health care systems, while owned by their local communities or counties, benefit from the shared strength and financial resources of Advanced Health Systems, as well as the most advanced technology in primary health care delivery and small hospital management available in the country. Frequently, the communities have not previously had the managerial support necessary to overcome the effects of maldistribution of health care resources. In order to meet these needs, the management and medical specialists of Advanced Health Systems provide support to our local administrators and staffs in communities throughout the Western and Midwestern areas of the United States. These support services are generally delivered from locations in the West in Irvine, California, and Salt Lake City, Utah, and St. Louis, Missouri, in the Midwest.

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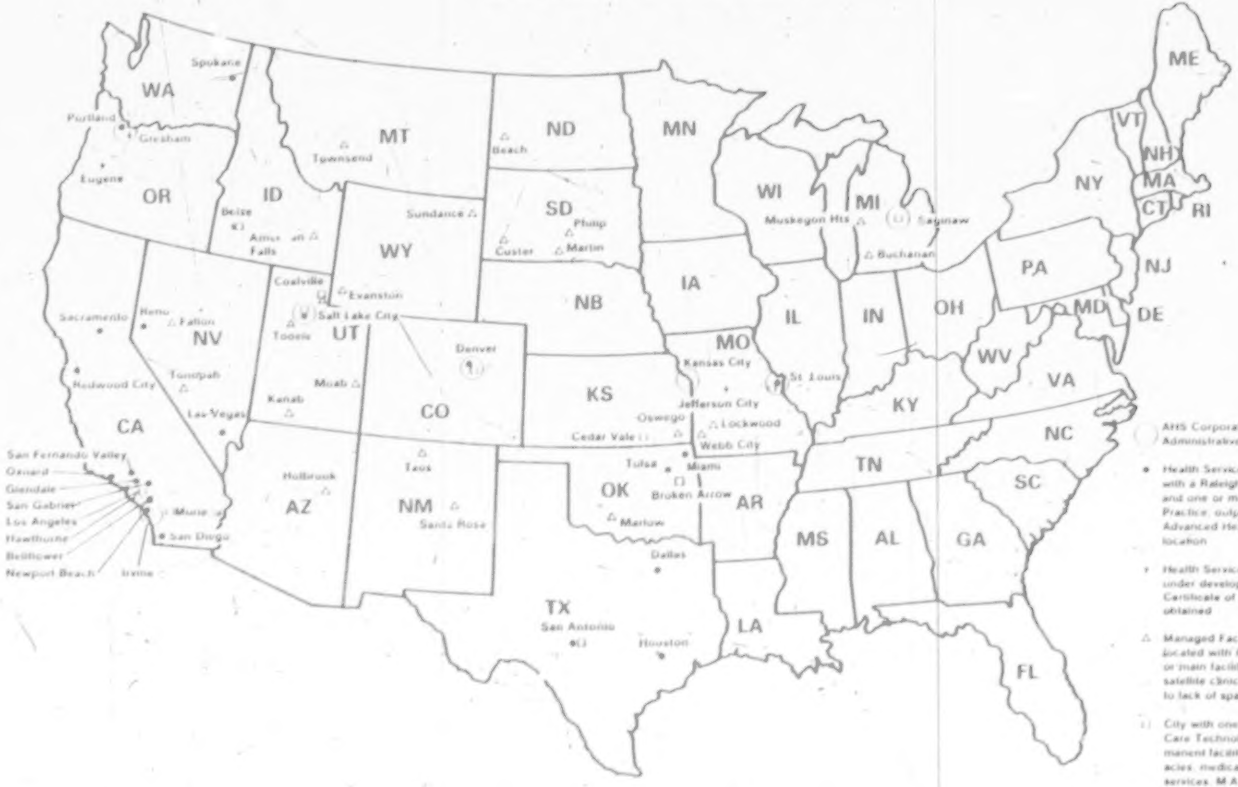
As a leader in the nation's health care industry, Advanced Health Systems has established close, professional relationships with several universities, health care institutions, and organizations. Through the sharing of specialized expertise and resources with other leaders in the health care field, Advanced Health Systems maintains continuing state-of-the-art quality in the services provided to our clients and patients by all three major operating groups.

ADVANCED HEALTH SYSTEMS, INC. LOCATIONS OF OWNED OR MANAGED HOSPITALS, AND OTHER AHS FACILITIES


WA
Spokane
Portland
Gresham
Eugene
OR
ID
Boise
American Falls
MT
Townsend
ND
Beach
MN
WI
MI
Muskegon Hts
Saginaw
Buchanan
ME
VT
NH
MA
CT
RI
NY
NJ
PA
DE
MD
SD
Philip
Custer
Martin
WY
Sundance
Evanston
Coalville
Salt Lake City
Tooele
UT
Moab
Kanab
NV
Reno
Fallon
Tonopah
Las Vegas
CA
Sacramento
Redwood City
San Fernando Valley
Oxnard
Glendale
San Gabriel
Los Angeles
Hawthorne
Bellflower
Newport Beach
Irvine
Murie
San Diego
AZ
Holbrook
NM
Taos
Santa Rosa
CO
Denver
NB
IA
IL
IN
OH
WV
VA
KS
MO
Kansas City
Jefferson City
St. Louis
Oswego
Cedar Vale
Lockwood
Webb City
OK
Tulsa
Miami
Broken Arrow
Marlow
AR
KY
TN
NC
SC
GA
AL
MS
LA
TX
Dallas
San Antonio
Houston
FL

○ AHS Corporate and Other Administrative Offices

● Health Services Group cities with a Raleigh Hills Hospital and one or more Professional Practice, outpatient, or Advanced Health Center location

+ Health Services Group cities under development with Certificate of Need already obtained

△ Managed Facilities Group located with City of Hospital or main facility shown, satellite clinics not shown due to lack of space

□ City with one or more Health Care Technology Group permanent facility, such as pharmacies, medical supplies and services, M.A.C., management services. Not shown are some major contract service client locations due to lack of space

OCTOBER 1981

EVALUATION OF SAVINGS

As referenced in the footnote to the Executive Summary, five sources of savings have been derived as follows:

A. Immediate savings by reduction in current rate of payment on charges: $488,199,000.

According to the current best estimate of the Federation of American Hospitals, the national average for payment on charges is 88%. Since we are proposing a flat rate of 75%, this is a reduction of 13% from the present rate.

With the average charge per day at $322.53 in 1980 (1) and a projected rate of increase (2) bringing it to $420.59 by 1982, and with a national estimate of 27 beds needed for alcoholism per 100,000 population (3), and with the 1980 census reporting an overall population of 226,504,825, we can estimate the current need for beds for alcoholism at: 61,156.

Using these figures, the 1982 national charges for alcoholism are: 61,156 beds x 365 days x $420.59 = $9,388,438,474.

A current estimate (3) of 40% is given as the percent of beds devoted to Medicare beneficiaries in 1980. Given the trend toward an older population, it is safely conservative to use this 1980 percentage to estimate the 1982 Medicare mix. Forty percent of the 1982 estimate of national charges for alcoholism is: .40 x $9,388,438,474 = $3,755,375,389.

Reducing this figure by 13% saves: $488,198,800.

B. Reduction in our administrative costs: $6,115,000.

We know from experience that our Medicare administrative costs are about $100 per bed, an amount based primarily on the intermediary and HCFA functions arising directly from cost reimbursement. We do not include in this figure administrative costs associated with audits of charges and service reviews such as those arising from PSRO functions.

From the estimate in "A," above, that the national need for beds in alcoholism is 61,156, we find that $100 x 61,156 = $6,115,600.

C. Savings through fewer clients needing retreatment: $300,430,000.

Based on our experience treating Medicare alcoholics, 5% is the minimum reduction in retreatments necessary to break even with the proposed change to 75% charges reimbursement. Using a safer estimate of 8% reduction in retreatments, the savings in the 1982 national charges for Medicare alcoholism is .08 x $3,755,375,389 = $300,430,031.

D. Savings through reduced cost of treatment: $225,322,000.

With the freedom to choose the treatment best suited to each client, some will be using the less expensive outpatient alternative as an adjunct or perhaps instead of inpatient treatment. If we assume a 40% reduction in the cost of treatment for 15% of clients, the savings on charges nationally is: .40 x .15 x $3,755,375,389 = $225,322,523.

E. Savings from reduced associated illness, illnesses where alcoholism contributes but is not diagnosed as the primary cause: $???

Several sources (5)(6)(7) have estimated a substantial percentage of non-alcoholism hospital admissions are, in fact, alcoholism related, but we feel a solid estimate is not possible at this time. A sensitive overview of the many interactions in the health care delivery system is required to derive this number for dollar savings . . . although it may well be the largest of the numbers listed.

Given the inevitable improvement in treatment that will come from the provider's having the freedom and financial incentive to achieve sobriety for Medicare clients, and given the motivation of the Medicare client to comparison shop for dollar value, our estimate of over a billion dollars of savings annually in the second year and of half a billion immediately is a conservative estimate of the dollars that government can save in achieving public good.

Were there no financial benefit in our proposal to reimburse 75% of charges for treating alcoholism, it would stand on its merit as a humanitarian step in improving the alcoholic's chance of recovery.

References

1. Annual Report of the Washington State Hospital Commission, 1980, national figures based on A.H.A. estimates.

2. Rate Controls, vol. 5, No.7, August, 1981.

3. Nebraska Alcoholism Services System Plan, Nebraska Division on Alcoholism, Department of Public Institutions, revised January, 1977.

4. Advance Reports, Bureau of the Census, U.S. Department of Commerce.

5. Eckardt,M.J. et al., Health hazards associated with alcohol consumption, Journal of the American Medical Association, 246, 1981, 648-666.

6. Jones, K. R., and Vischi, T. R. Impact of alcohol, drug abuse, and mental health treatment on medical care utilization, Office of Program Planning and Coordination, ADAMHA, Rockville, MD.

7. Fourth Special Report to the U.S. Congress on Alcohol and Health from the Secretary of Health and Human Services, January, 1981

Chairman Jacobs. Thank you.

Mr. Gephardt?

Mr. Gephardt. Thank you, Mr. Chairman.

Mr. Phillips, you raised the question in your testimony about the business of preempting the State laws. You are concerned about that. I obviously understand your concern.

I hope you understand that in 850 we do not preempt State laws that have to do with quality or that promote quality of care.

Do you have any thoughts on that?

Mr. Phillips. I was thinking in the testimony, Mr. Gephardt, of laws having to do with licensure, certificate of need. Until those State laws are brought into conformity, or some of the problems involved in the preemption of those laws by your bill, then this transition period could produce some awkwardness. I don't think it is an insurmountable kind of thing.

Mr. Gephardt. I understand.

A number of you question the ability of consumers to make choice. Linda, you talk about your worry about the connection between the voluntary sector and competition. I guess I would like to ask two questions.

One, how do you square the contradiction in the idea that people cannot make choice on the one hand and the idea that everybody who is well is going to go into one plan? It seems to me there is a contradiction in those two ideas. I would like to comment on that.

Second, I would like to ask if you think that there is a better connection between voluntary sector and more regulation. Do you think that is a better approach, or do you think that competition, if we have to choose between one or the other, is a better approach than greater regulation?

Ms. Miller. There is no question that I think it is a better approach than regulation and would not support regulation. As I said, I think that the elements of the philosophy of competition is one that is compatible with hospitals. However, I think that 850 still does not address the issues of how the hospitals that are not-for-profit, and do exist to provide community services, and absorb bad debt, and provide charity care, how they in turn compete on the one hand when there is such stress on price, and on the other continue to offer the kinds of services that they have historically.

Mr. Gephardt. Would you not say that what we try to do with medicaid and what we do with the tax credit for people not now covered, and what we try to do with bad debts, in picking up 50 percent of bad debts, or at least attempt to try to deal with the problems that voluntary hospitals face?

Ms. Miller. I am sorry. Would you repeat that? I am not understanding the question.

Mr. Gephardt. The elements of the bill that deal with picking up 50 percent of bad debt, and the elements in the bill that try to raise medicaid to a national level, and the elements in the bill that offer a tax credit for individuals who do not now have employer paid premiums are all attempts—they may not be perfect in your eyes—but attempts to deal with the problem of not-for-profit hospitals, especially those of the innercity impact, with lots of patients who cannot pay.

Ms. **Miller**. That is correct, although I don't see that the tax credit really deals with the issue of the hospitals, so much as it deals with the recipient. I do think it still falls short of addressing the issue of the community hospital that is putting its effort and what we are calling profit back into breadth of service.

Where is the incentive to provide a service that is not a particularly cost effective one?

Mr. **Gephardt**. Do you not believe, though, that having a tax credit which would allow some people who do not now have health coverage to have health coverage would inure to the benefit of the providers who are impacted with people who now do not have coverage?

Ms. **Miller**. Yes, I do agree with that, and we completely support your move to federalize medicaid.

Mr. **Gephardt**. Mr. Dunn, your proposal is inventive and one that I want to study. I appreciate having it.

I am wondering if you think under the bills that are present, that allow freedom of providers, or insurance companies to put anything in the bill they want, do you think these services for alcoholics would be the kind of service that competitive plans would put in their plans for medicare patients or others?

Mr. **Dunn**. Yes. I think these types of innovations are more likely to be widely adopted under your proposal than they are under the existing structure. Clearly, under such a system, the patient, employer, the group that is doing the purchasing, is more likely to ask the question, "is what I am buying effective, not just inexpensive?"

I sincerely believe that the competitive proposals will act to improve health outcomes as well as contain the cost.

So, I believe these are very compatible, which is why I believe that these steps which we have outlined here today are perfectly consistent with your proposal.

Mr. **Gephardt**. Thank you all very much.

Thank you, Mr. Chairman.

Chairman **Jacobs**. I echo the sentiments of Mr. Gephardt. Each of you has made a substantial contribution to the record, for which we are grateful.

The next witness is Dr. James B. Hutt, Association of American Physicians and Surgeons.

Dr. Hutt, you are welcome. You may proceed in your own manner, either including your full formal statement for the record and summarizing it, or reading it as you choose.

STATEMENT OF JAMES B. HUTT, JR., M.D., ON BEHALF OF THE ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, INC.

Dr. **Hutt**. Thank you. I am going to read my statement.

Mr. Chairman and members of the subcommittee, my name is James B. Hutt, Jr. I am a physician in private practice in Warrenton, Va. I am testifying on behalf of the Association of American Physicians and Surgeons, a national organization of physicians which, since 1943, has been promoting high standards of medical care for the American people through the preservation and strengthening of the private practice of medicine.

The legislation under consideration here today, the so-called procompetition plans, is designed to bring about major and dramatic changes in our present system of medical care.

We need to step back and take a hard look at where it is leading us and decide if we really want to go there. What is the goal we are seeking? Isn't it the attainment of the best possible medical care for the greatest number of American citizens? If so, then how can we best reach that goal?

The proponents of the procompetition bills evidently feel that they will instigate changes in our present system that will bring us closer than we are now to the stated goal. We of the Association of American Physicians and Surgeons disagree and intend to show you that this procompetition legislation can only bring about a deterioration of the quality and quantity of medical care that we have enjoyed in the past.

Having witnessed 40 years of increasing waste and inefficiency in government, the American people stand solidly behind their President when he now calls for cuts in the Federal regulatory agencies and their intrusion into the private sector. In this climate, the term "procompetition" is beguiling because it suggests a lessening of governmental control and a return to free enterprise.

These bills, however, do nothing of the sort. They are mislabeled as procompetition. They are, in fact, pro-Government control and determination of our health care system.

Although my comments are directed at all three bills, I will specifically address H.R 850, the most complex and lengthy of the three.

The authors of H.R. 850 state, in section 2(a), that the "* * * Congress finds that the majority of Americans are receiving health care of a quality unmatched elsewhere in the world * * *" The Association of American Physicians and Surgeons agrees and maintains that the principal reason why this is so is the freedom of the private American physician to innovate and to seek the best possible care for the patient.

The authors of H.R. 850, however, use that foundation statement to construct a new superstructure of Government intrusion into health care. They take, as one of their building blocks, the statement "that the method by which health care is financed and delivered is inflationary." By any strict interpretation this is nonsense, since by definition inflation is an increase in the money supply. One might concede, however, that the present huge expenditures of the Federal Government in health care contribute to the ever-growing Federal deficits which, when monetized, do cause inflation.

Paradoxically, the authors openly recognize that previous Federal intrusions into medical care have been a failure. Section 2(b)3, Excessive Government Regulation, reads as follows:

> * * * Continually increasing and complex Government regulations of the economic aspects of the health care delivery system has proven ineffective in restraining cost and is itself expensive and detrimental to the care of patients."

Milton Friedman couldn't have said it any better.

The obvious corollary to the above is that removing the heavy hand of Federal regulation from the health care system would result in better and less expensive medical care. But what does the bill propose? Increasingly, massive, and all-pervasive Federal controls.

The quotation just referred to is one of seven specific deficiencies in the present system that are listed. There is only one other of the remaining six that has any real significance, and that is section 2(b)(4) which deals with third party payment systems and their impact on the cost of medical care.

The observation is made that third-party payers tend to insulate the patient, the physician and the hospital from the need to consider the costs of treatment. Since the Federal Government is the largest single third-party payer, logic would suggest that removing it from this triangle would at least partially solve the deficiency noted. Do the authors suggest this? Not at all. They use 145 more pages to delineate the role to be played by the Federal Government in a system of health care delivery in which the individual is separated from his doctor by three third parties: the employer, the carrier, and the Federal Government.

We do not have the time here to present a detailed analysis of this incredibly complex, tortuous, and excessively vague document that is called the National Health Care Reform Act of 1981. Suffice it to say that its complexity and length put it out of reach of the understanding of the average employer or individual. This factor alone should militate against its passage.

Embodied in this bill are at least 50 major revisions of the health care system that usurp the power and prerogatives of the individual and State and local governments. These revisions affect the employer, the employee, the individual, the insurance companies, the hospitals, the health care professionals, the State and local laws, Federal laws, and tax laws. Just a few of the most ominous are:

First, Federal subsidy is to be provided to all Americans for their health care. This provision assures Federal control over the system since it is axiomatic that what the Federal Government subsidizes it must control.

Second, the employer's tax deductions for providing health insurance to his employees are limited and defined as Federal contributions to the employer.

Third, participation in the system is limited to qualified plans as defined by the Federal Government and defined without judicial recourse.

Fourth, it establishes a gigantic new Federal agency, the Health Benefits Assurance Corporation, of incalculable cost, which is off budget and exempt from budgetary limitations and yet it is funded from two different Federal sources.

Fifth, it creates new Federal courts, the Health Court and Health Court of Appeals, of which the former denies the individual his constitutional right to trial by jury.

Sixth, it preempts all State and local laws that are in conflict, including those prohibiting the corporate practice of medicine.

It is obvious from even this superficial examination that pro-competition health legislation, such as H.R. 850, is a snare and a delusion designed to attain total Federal control over the health care system. It is a concept that smacks of totalitarianism and is repugnant to Americans.

We now have the best medical care in the world in spite of, not because of, the intrusion of Federal controls. Let's seek to improve health care by following the principles that have served our Nation and our health care system so well in the past and that have made us what we are today. Our Nation is precariously balanced on the brink of national bankruptcy because we have strayed too far from those principles and allowed the Federal Government to ignore and exceed at will the restraints imposed by the Constitution.

Now is the time to consider the disengagement of the Federal Government from the health care system, not new health bureaucracies of incalculable cost and complexity.

Now is the time to support the expressed will of the American people to reduce the pervasive influence of the Federal Government in our society and our daily lives.

Now, therefore, is the time to bury these so-called pro-competition bills and instead finally to get to work to get the Federal Government out of the health care delivery system. That is our prescription for improved and revitalized health care for this country, as well as prosperity and freedom for all of us.

Thank you.

Chairman **Jacobs**. Thank you, Doctor.

Mr. Gephardt.

Mr. **Gephardt**. Thank you, Mr. Chairman.

Dr. Hutt, I would like to address a couple of the points you make on page 5. The first point is, the bill calls for a Federal subsidy to be provided to all Americans. And then you say that this provision would assure Federal control over the system since it is axiomatic what the Federal Government subsidizes, it must control.

Do I take it from that statement that you would prefer that we would get rid of medicare and medicaid and get rid of the exclusion and the deduction that now exists in the code for premiums paid by employers?

Dr. **Hutt**. Mr. Gephardt, it is my impression that we are in trouble in this country because of the huge expenditures made by the Federal Government. One thing that we can do is return health care to the States and local governments. Obviously this Federal involvement would have to be phased out. But it should include medicare and medicaid. Certainly it should not include federalizing medicaid as I have heard here today.

Mr. **Gephardt**. So you would be in favor of the Federal Government over a period of time getting out of medicare and medicaid and letting the States handle it themselves.

Dr. **Hutt**. Correct.

Mr. **Gephardt**. And what about the subsidy in the tax code, by the tax exclusion and the deduction for both employers and employees?

Dr. **Hutt**. My feeling here is that there is a sentiment expressed in that statement whereby the employer is to be given a contribution. This contribution is a tax deduction. It suggests that whatever the employer makes belongs to the Federal Government, and by giving him a deduction they are giving him a contribution. Of course, this is not true.

Mr. **Gephardt**. My question is, if we want to get the Government out of health care entirely, one way to do it would be to take away the exclusion. We give an exclusion now to employees for money that is paid by an employer for health care premiums. We give an employer a business deduction for payment of that kind. We give anyone, any individual, a deduction for health care costs in a year that are over a certain level.

My question is, If you believe that Federal subsidies lead to Federal control, do you not agree that we ought to get rid of those exclusions and deductions so the Federal Government is total neutral? We don't give a deduction for exclusion if your employer pays for your lunch or for your house. Why should we give it for medical care?

Dr. **Hutt**. It seems to me there are certain deductions that are given employers and they provide some things for the employees as an enticement to employment.

Mr. **Gephardt**. There are none that I know of, for food or for housing or for anything else. That is all seen as income to the employee.

Dr. **Hutt**. There is a retirement plan that I recall that the employer contributes to the retirement plan of his employee, which is tax deductible.

Mr. **Gephardt**. But that is a Federal subsidy. We are treating that kind of expense differently than anything else.

Dr. **Hutt**. Maybe I don't understand your question.

Mr. **Gephardt**. By treating that income differently than wages, for instance, we are giving a positive Federal subsidy and an incentive for people to use those kinds of things: health care or pension plans. Whatever we give a tax break for, we are giving in effect a subsidy, those things should be treated like wages under a neutral system.

My question is, if your point is that we ought to get rid of Federal subsidy for health care, then it would lead me to the conclusion that you conclude that we ought to get rid of those kinds of deductions and exclusions.

Dr. **Hutt**. It seems to me that providing health care to employees is a legitimate expense of doing business, as is providing, say, transportation of other things.

Mr. **Gephardt**. Should we exclude those payments from the employee's income which we do now in an unlimited fashion?

Dr. **Hutt**. I think eventually if the States assume—the States and localities assume responsibility for the health care system rather than Federal Government, you would exclude it on Federal income?

Mr. **Gephardt**. Thank you very much.

Chairman **Jacobs**. Mr. Duncan?

Mr. **Duncan**. Thank you, Mr. Chairman.

I have no questions other than to thank Dr. Hutt for appearing.

Chairman **Jacobs**. I always take my turn at the end.

Your allusion to the regulations that medical doctors have suffered under medicare, would you spread on the record a few of those—a few examples of regulations that have applied to medical doctors that have adversely affected their practices?

Dr. **Hutt**. Under medicare?

Chairman **Jacobs**. Yes.

Dr. HUTT. I don't participate in the medicare system personally, so I am really not—I don't know that I can answer the question, but it seems to me that under medicare, if a doctor participates and takes payment directly from the Government, he is obliged to accept what is considered the normal rate of payment; that is one obligation that he has, the fee schedule.

Chairman JACOBS. You are under the impression that he or she could not charge more?

Dr. HUTT. He can charge more, but the Government pays a certain set established fee.

Chairman JACOBS. You mean that doctor is forced to accept money from the Government to a certain extent?

Dr. HUTT. If he accepts medicare payment.

Chairman JACOBS. Any worse regulation than that that you could think of?

Dr. HUTT. Under the medicare system directly, I don't know of any. Of course, there are PSRO's, health system agencies and other things which are not part of the medicare system itself.

Chairman JACOBS. I just wondered, because my father says I am cursed with a memory. I recall in 1962 that the American Medical Association was convinced, as I understood it, almost that you would be wearing a uniform today if medicare passed.

I gather you would agree that some of the more heinous anticipations of regulation have been falsified by events and apparently the worst regulation is that the doctor gets some money from the Federal Government in connection with his fee?

Dr. HUTT. I think you have to look at the whole picture; you can't just look at medicare. You have to look at Federal involvement as a whole. The answer to your question is that there is tremendous Federal involvement. Again I refer to PSRO and health systems agencies.

Chairman JACOBS. How does that work as a practical matter? Let's take the PSRO. How does that adversely affect your practice, Doctor.

Dr. HUTT. Again it does not affect my practice at the present time because I do not participate in the programs, but to a physician who does, it does affect him because he is subject to the rules and regulations of PSRO's.

Chairman JACOBS. What are those that he or she is actually subjected to?

Dr. HUTT. As you probably know, PSRO law was passed back in 1972, as part of the Social Security Act. It provided a kind of cookbook approach to the practice of medicine. It establishes that doctors shall practice medicine in a certain way.

Chairman JACOBS. The statute itself does?

Dr. HUTT. Yes.

Chairman JACOBS. It is not just a peer group review?

Dr. HUTT. No. This is in the statute.

Not only that, it defines whether or not a physician admit a patient to a hospital, what hospital he may be admitted to.

Chairman JACOBS. Who makes that decision?

Dr. HUTT. PSRO, the organization, local organization.

Chairman JACOBS. Those would be what, medical doctors in the community?

Dr. **Hutt**. Well, presumably they are either appointed or hired for that purpose by the Government, either way. They may not be physicians.

Chairman **Jacobs**. See, I am recalling testimony before this subcommittee from the American Medical Association that as a practical matter, PSRO's ordinarily ask a physician, for example, whether we find this to be healthy tissue, or an organ that has been removed; we are wondering why it was removed.

It is rather an informal thing in most communities.

Dr. **Hutt**. This is not so at all. PSRO is established on a regional basis. There are 10 PSRO organizations, one in each Federal region.

Under them, there are area PSRO's, and these, in turn, oversee the performance of the doctors in the hospital, and eventually, if the law were extended to its total possibilities, would include overseeing the practice of the physician in the office.

Chairman **Jacobs**. I was just talking about living, breathing. This doctor, I can't recall his name; he is very articulate. He testified before our committee on behalf of the AMA a few months ago.

He is a California practitioner. He described it as I have repeated, as the record will show. I expect there could be disagreements.

Dr. **Hutt**. The only reason why he would say that is because perhaps the PSRO has not become as all-pervasive as it might.

Chairman **Jacobs**. My question was directed to what might happen. I think it is important that this committee record show any undue or any Government regulation that adversely affects the practice of medicine.

Some people have even gone so far as to suggest that under the medicare program, there is insufficient regulation. That is to say in some cases, a doctor might charge the fee he would have charged anyway, and also take the reimbursement as a windfall.

I am not saying I am particularly sympathetic with that, but there are various points of view about whether there is too much regulation or too little regulation.

I think any information that the profession can give to the record of this committee in terms of unreasonable or even adverse regulation in the medical practice would be welcomed.

Dr. **Hutt**. Health systems agencies have played a part in limiting the use of the CT scan, computerized use of X-ray, very expensive equipment.

When it first came out, health systems agencies were involved in limiting its use to certain hospitals on the idea that it would help contain costs. I think that——

Chairman **Jacobs**. That would be an example of regulation?

Dr. **Hutt**. This is an example of the action that has happened.

Also in my community, the health systems agencies made an edict that would have closed the pediatrics ward and the obstetrical ward of that hospital.

The idea being that they were not well utilized and therefore they would close them down and make the local patients go to other hospitals. That particular requirement was dropped because of a local outcry. There is no reason to anticipate that it wouldn't happen again.

Chairman JACOBS. Doctor, we are very grateful to you for your testimony. Thank you.

Our next testimony will come from a panel consisting of Susan J. Scott, director of the Government and Legal Affairs Division of the American Occupational Therapy Association, and Paul Gilbride, president, Gilbride Insurance, Inc.

If these witnesses are here, we would appreciate them coming forward.

Also the National Federation of Societies for Clinical Social Work, represented by Kenneth L. Adams, the Washington representative.

I believe that Ms. Scott is also representing the American Occupational Therapy Association, the American Physical Therapy Association, the American Association of Respiratory Therapy; the National Easter Seal Society and the American Speech, Language and Hearing Association.

If that is not correct, someone correct it.

STATEMENT OF SUSAN J. SCOTT, OTR, DIRECTOR, GOVERNMENT AND LEGAL AFFAIRS DIVISION, AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, REPRESENTING AMERICAN PHYSICAL THERAPY ASSOCIATION, AMERICAN ASSOCIATION OF RESPIRATORY THERAPY, NATIONAL EASTER SEAL SOCIETY, AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION, AND NATIONAL ASSOCIATION OF REHABILITATION FACILITIES

Ms. SCOTT. That is correct. We appreciate the opportunity to be here today.

Since you introduced the groups I am representing, I will not repeat those.

We appreciate the opportunity to be here today to comment on various proposals to stimulate competition in the financing and delivery of health care.

Mr. Chairman, we support a careful review and analysis of any proposal purporting to reform our Nation's health care delivery system and reduce the rate of increase in health care costs. From our perspective, one of the main reasons for the increase in national health expenditures has been the complex financial disincentives to delivering health care in the most cost effective manner. Increased competition may alleviate these disincentives, but we are concerned that a single agenda of reducing overall costs may result in a reduction of affordable services and perpetuate certain inequities in our present system.

In addition, we feel that the implicit general criticisms of the medicare and medicaid programs are unwarranted. Although both programs contain many disincentives to the cost effective use of health care, medicare, and medicaid have greatly increased the accessibility to health care by the aged, disabled, and disadvantaged. Any restructuring of our reimbursement system should not reduce access to basic health care services, but should address the underlying financial disincentives to efficient delivery, such as the present emphasis on institutional care.

The purpose of our comments at this point is to surface several issues we feel necessary to any discussion of a competitive approach to health care financing. We will briefly address the following issues: adequacy of coverage in the basic plans, avoidance of institutional bias, maintenance of quality, catastrophic coverage, out-of-pocket expenditures, and the proposed voucher system for medicare.

ADEQUACY OF COVERAGE—REHABILITATIVE SERVICES

With respect to adequacy of coverage, rehabilitative services are an integral part of medical treatment and should, therefore, be mandated in the coverage requirements for any qualified health plan. We do not consider any benefit package to be adequate unless it includes these basic rehabilitative services.

We believe the issue is not whether minimum services should be mandated—indeed, some benefits are mandated in all the bills under discussion—but rather what constitutes basic minimum coverage. It is unrealistic to expect that consumers will be able to fully understand the complex array of services which they might need, so we feel it is crucial that Congress mandate an adequate scope of basic services to protect consumers from misleading exclusions of necessary services.

Competition among plans should not be on the provision of minimum benefits, but on price, quality, accessibility, and out-of-pocket expenditures. We are not suggesting that Congress mandate unlimited rehabilitative services, but these services should be subject to the same coverage criteria as other services covered under the minimum benefit. We do assert, however, that the minimum coverage of any plan should include those services that the public will certainly need, including medically necessary rehabilitative services.

AVOIDANCE OF INSTITUTIONAL BIAS

The medicare program and virtually all private plans encourage, or in a sense mandate, overutilization of expensive institutional care. This occurs because of financial barriers to consumer use of alternative settings such as free standing outpatient rehabilitation centers, home care programs, and ambulatory care centers. This is clearly not cost effective and prevents consumers, in conjunction with their physicians, from freely choosing the setting in which they wish to receive treatment. This subcommittee has been responsive to this problem, having approved legislation to make comprehensive outpatient rehabilitation facilities producers under medicare. Those of us concerned with this program are still working to get this provision implemented by the Health Care Financing Administration. One alternative setting, home care, has proven not only to be cost effective, but to be a benefit which can be included in an insurance package with no additional increase in premiums. Blue Cross of Maryland reported recently that its home care program, which includes rehabilitative services, saved $750,000 in 1980 by reducing hospital stays 11.4 days. Blue Cross of Cleveland has recently added a home care benefit package to all its plans' local contracts reporting that, "The benefits can be added with no increase in rates because * * * it is a less costly alternative to inpatient care."

We assert, therefore, that all commonly recognized treatment settings should be covered by the plans so consumers can use them when medically appropriate. Cost containment pressures within the plan should operate to move the treatment to the least costly setting.

OUT-OF-POCKET EXPENDITURES

With respect to out-of-pocket expenditures, we are primarily concerned with two issues, their application and the maximum amount.

To avoid establishing financial disincentives to using any particular setting or service, we recommend that out-of-pocket expenditures be proportionally applied to all settings and services within the plan. This establishes an essentially neutral situation in which no setting, service, or provider is favored over another. This proposal is not inconsistent with our recommendation that all settings and minimum services be covered. We are fearful that a disproportionate application of out-of-pocket expenditures would discourage the consumer, and the physician, from selecting the most cost-effective and medically appropriate health settings.

We are also concerned that the various maximum limits in the three competition proposals on out-of-pocket expenditures before catastrophic coverage is applied may be too high. We are not opposed to the concept of using these out-of-pocket expenditures to discourage inappropriate utilization and encourage competition, but such limits should not be so high as to inflict severe financial harm on low middle, and middle income families who are seriously harmed by catastrophic illness or to discourage them from seeking proper medical attention. We recognize that the plans may compete by offering fewer out-of-pocket expenditures, but we urge further study in this area and suggest that consideration be given to lowering the maximum level.

QUALITY MAINTENANCE

It is not clear in any of the bills how a minimum level of quality of care will be assured. We understand that quality of care is one of the factors that competition will be focused on, but we are concerned regarding the apparent lack of minimum requirements for quality care. In this regard, we are speaking specifically of the types of services provided and the qualifications of the service providers.

We believe that some minimum standards of quality must be included in any health care structure in order to protect the public from an unreasonably low level of care.

We are very concerned with one particular aspect of the catastrophic coverage provisions of these bills.

As presently drafted, all three bills under discussion mandate that once out-of-pocket expenditures reach the applicable limit, catastrophic coverage must be provided by the plan but only for those basic health care services identified by the plan.

Two points should be made.

First, the out-of-pocket expenditure limit is calculated on a calendar or plan year basis, and the consumer could conceivably spend up to that limit each year without catastrophic protection. That could be a lot of money each year for some people.

Second, if rehabilitative services are not adequately covered under the basic health care services provisions of a plan, such services will not be adequately covered under catastrophic protection.

People who have experienced a catastrophic injury or illness are those who will be most in need of rehabilitative services. Therefore, it is even more important for rehabilitative services to be mandated under the minimum basic health care services provisions.

Does this red light mean something important here, like stop?

Chairman JACOBS. Ms. Scott, we try to accommodate the witnesses.

As I understand, the witnesses were told there is a 5-minute rule and we would hope that omitted matter from formal statements might evolve in the questions.

However——

Ms. SCOTT. I thought that might be what it meant.

Chairman JACOBS. You just go ahead.

Ms. SCOTT. Thank you, Mr. Chairman. I am almost finished.

Chairman JACOBS. We at least appreciate that.

Ms. SCOTT. I would like to make a comment here about the voucher system for medicare.

H.R. 850 proposes a new system of medicare vouchers which could be used by medicare and medicaid beneficiaries to purchase coverage by a qualified private insurance plan.

We do not reject the possibility that such a proposal may improve our present system, but we are concerned about a particular provision regarding vouchers for medicare beneficiaries.

Under the proposed system beneficiaries would receive a predetermined amount in a voucher with which they could purchase any qualified plan they desire.

A key element of the provision specifies that if the medicare beneficiary purchases a plan with a premium below the voucher, they would be able to keep the difference as a tax-free refund.

We recognize that this is designed to further instill competition into the system, but we fear that the unintended effect could be to place the medicare beneficiary at risk.

If the beneficiary purchases a less expensive plan in order to save or receive extra money, the result may be minimum coverage and high out-of-pocket expenditures.

In other words, the beneficiary may save some money in purchasing the plan, but pay far more than that in out-of-pocket expenditures or for noncovered services.

Further, if the out-of-pocket expenditures are high enough, the beneficiary may become dependent on the public sector through some other program.

We feel that such a myopic provision puts the medicare beneficiary in an untenable position and forces them to make a choice which they should not be forced to make.

We recommend a restructuring of this proposal to eliminate the need for these kinds of decisions.

Two other issues regarding qualified plans that should be addressed are those of coverage or preventive care service and mental health.

We commend Representative Gephardt and Senator Hatch for their foresighted approach in recognizing the need for and the cost effectiveness of preventive care services as part of any qualified health plan.

We believe the inclusion of such services is one of the most important aspects of the bills under consideration and we urge that any preventive program include a broad range of services such as those specified in S. 139.

However, we note that H.R. 850 specifically excludes items and services related to mental or emotional illness or chemical dependency.

We feel that such a specific exclusion is totally unreasonable and that a minimum level of mental health services should be included as part of basic health care services.

In summary, we believe H.R. 850, S. 139, and S. 433 contain innovative competition-based concepts that may help in our continuing attempts to improve our national health care delivery system.

We urge, however, that careful attention be given to improving, not just altering, the health care system by insuring adequate coverage requirements, maintenance of quality, and freedom of choice in the service setting.

The objective of any health care approach—including a competitive one—should not be solely to reduce health costs, but should continue to improve the accessibility and availability of quality health care to all consumers in the most cost effective manner.

[The prepared statement follows:]

STATEMENT OF AMERICAN OCCUPATIONAL THERAPY ASSOCIATION, INC.; AMERICAN PHYSICAL THERAPY ASSOCIATION; NATIONAL EASTER SEAL SOCIETY; NATIONAL ASSOCIATION OF REHABILITATION FACILITIES; AMERICAN ASSOCIATION FOR RESPIRATORY THERAPY; AND AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Mr. Chairman and members of the Subcommittee, I appreciate the opportunity to be here today to comment on various proposals to stimulate competition in the financing and delivery of health care.

I am Susan Scott, an occupational therapist and Director of the Government and Legal Affairs Division of The American Occupational Therapy Association, Inc. In my capacity today, I also represent the views of a Coalition of Rehabilitative Service Providers including the American Physical Therapy Association, the National Easter Seal Society, the National Association of Rehabilitation Facilities, the American Association for Respiratory Therapy and the American Speech-Language-Hearing Association. Our testimony today will summarize the concerns and recommendations of this Coalition; each association reserving the right to submit its own more detailed testimony for the written record. Accompanying me is Mr. Paul Gilbride, President of Gilbride Insurance, who will present his views on the need for including rehabilitative services in the basic health provision of any insurance policy.

Mr. Chairman, we support a careful review and analysis of any proposal purporting to reform our nation's health care delivery system and reduce the rate of increase in health care costs. From our perspective, one of the main reasons for the increase in national health expenditures has been the complex financial disincentives to delivering health care in the most cost-effective manner. Increased competition may alleviate these disincentives, but we are concerned that a single agenda of reducing overall costs may result in a reduction of affordable services and perpetuate certain inequities in our present system.

In addition, we feel that the implicit general criticisms of the Medicare and Medicaid programs are unwarrented. Although both programs contain many disincentives to the cost-effective use of health care, Medicare and Medicaid have greatly increased the accessibility to health care by the aged, disabled and disadvantaged. Any restructuring of our reimbursement system should not reduce access to basic health care services, but should address the underlying financial disincentives to efficient delivery, such as the present emphasis on institutional care.

The purpose of our comments at this point is to surface several issues we feel necessary to any discussion of a competitive approach to health care financing. We will briefly address the following issues: adequacy of coverage in the basic plans, avoidance of institutional bias, maintenance of quality, catastrophic coverage, out-of-pocket expenditures, and the proposed voucher system for Medicare.

Adequacy of Coverage - Rehabilitative Services

Rehabilitative services are an integral part of medical treatment and should, therefore,be mandated in the coverage requirements for any qualified health plan. We do not consider any benefit package to be adequate unless it includes these basic rehabilitative services.

We believe the issue is not whether minimum services should be mandated -- since some benefits are mandated in all the bills under discussion -- but rather what constitutes minimum coverage. It is unrealistic to expect that consumers will be able to fully understand the complex array of services which they might need, so it is crucial that Congress mandate an adequate scope of basic services to protect consumers from misleading exclusions of necessary services.

Competition among plans should not be on the provision of minimum benefits, but on price, quality, accessability, and out-of-pocket expenditures. We are not suggesting that Congress mandate unlimited rehabilitative services, but these services should be subject to the same coverage criteria as other services covered under the minimum benefit. We do assert, however, that the minimum coverage of any plan should include those services that the public will certainly need, including medically necessary rehabilitative services.

Avoidance of Institutional Bias

The Medicare program and virtually all private plans encourage, or in a sense mandate, overutilization of expensive institutional care. This occurs because of financial barriers to consumer use of alternative settings such as free standing outpatient rehabilitation centers, home care programs and ambulatory care centers. This is clearly not cost-effective and prevents consumers, in conjunction with their physicians, from freely choosing the setting in which they wish to receive treatment. This Subcommittee has been responsive to this problem, having approved legislation to make comprehensive outpatient rehabilitation facilities providers under Medicare. Those of us concerned with this problem are still working to get this provision (Sec. 933 of the Omnibus Budget Reconciliation Act of 1980) implemented by the Health Care Financing Administration (HCFA). One alternative setting, home care, has proven not only to be cost-effective, but to be a benefit which can be included in an insurance package with no additional increase in premiums. Blue Cross of Maryland reported recently that its home care program, which includes rehabilitative services, saved $750,000 in 1980 by reducing hospital stays by an average of 11.4 days. Blue Cross of Cleveland has recently added a home care benefit package to all its plan's local contracts reporting that, "The benefits can be added with no increase in rates because. . .it is a least costly alternative to inpatient care."

We assert, therefore, that all commonly recognized treatment settings should be covered by the plans so consumers can use them when medically appropriate. Cost containment pressures within the plan should operate to move treatment to the least costly setting.

Out-of-Pocket Expenditures

We are primarily concerned with two issues regarding out-of-pocket expenditures: their application and the maximum amount.

To avoid establishing financial disincentives to using any particular setting or service, we recommend that out-of-pocket expenditures be proportionally applied to all settings and services within the plan. This establishes an essentially neutral situation in which no setting, service or provider is favored over another. This proposal is not inconsistant with our recommendation that all settings and minimum services be covered. We are fearful that a disproportionate application of out-of-pocket expenditures would discourage the consumer, and the physician, from selecting the most cost-effective and medically appropriate health settings.

We are also concerned that the various maximum limits in the three competition proposals on out-of-pocket expenditures before catastrophic coverage is applied may be too high. We are not opposed to the concept of using out-of-pocket expenditures to discourage inappropriate utilization and encourage competition, but such limits should not be so high as to inflict severe financial harm on low middle and middle income families who are seriously harmed by catastrophic illness or to discourage them from seeking proper medical attention. We recognize that the plans may compete by offering fewer out-of-pocket expenditures, but we urge further study in this area and suggest that consideration be given to lowering the maximum level.

Quality Maintenance

It is not clear in any of the bills how a minimum level of quality of care will be assured. We understand that a high level of quality is one of the factors that competition will be focused on, but we are concerned regarding the apparent lack of minimum requirements for quality care. In this regard we are speaking specifically of the types of services provided and the qualifications of the service providers.

We believe that some minimum standards of quality must be included in any health care structure in order to protect the public from an unreasonably low level of care. While we recognize that the system would allow consumers to change plans if they receive poor quality care, it has been our experience that inadequate health care is usually only identified by consumers after the fact. It would be regrettable to initiate a system which relegated quality health care to the domain of those who have learned from prior bad experience. We would hope, therefore, that minimum national standards of quality care would be included and we look forward to the opportunity to participate in their development. We also recommend that multidisciplinary patient care evaluation studies be required of participating practitioners and facilities to focus on outcome of care.

Catastrophic Coverage

We are very concerned with one particular aspect of the catastrophic coverage provisions of these bills. As presently drafted, all three bills under discussion mandate that once out-of-pocket expenditures reach the applicable limit, catastrophic coverage must be provided by the plan but only for those basic health care services identified by the plan.

Two points should be made. First, the out-of-pocket expenditure limit is calculated on a calendar or plan year basis, and the consumer could conceivably spend up to that limit each year without catastrophic protection. Secondly, and more importantly, if rehabilitative services are not adequately covered under the basic health care services provisions of a plan, such services will not be adequately covered under catastrophic protection. People who have experienced a catastrophic injury or illness are those who will be most in need of rehabilitative services. Therefore, it is even more important for rehabilitative services to be mandated under the minimum basic health care services provisions.

Voucher System for Medicare

H.R. 850 proposes a new system of providing direct health care contributions in the form of vouchers which would be used by Medicare and Medicaid beneficiaries to purchase coverage by a qualified private insurance plan. We do not reject the possibility that such a proposal may improve our present system, but we are concerned about a particular provision regarding vouchers for Medicare beneficiaries.

Under the proposed system, Medicare beneficiaries would receive a predetermined amount in a voucher with which they could purchase any qualified plan they desire. A key element of the provision specifies that if the Medicare beneficiary purchases a plan with a premium below the voucher, they would be able to keep the difference as a tax-free refund. We recognize that this is designed to further instill competition into the system, but we fear that the unintended effect could be to place the Medicare beneficiary at risk. If the beneficiary purchases a less expensive plan in order to save or receive extra money, the result may be minimum coverage and high out-of-pocket expenditures. In other words, the beneficiary may save some money in purchasing the plan, but pay far more than that in out-of-pocket expenditures or for non-covered services. Further, if the out-of-pocket expenditures are high enough, the beneficiary may become dependent on the public sector through some other program.

We feel that such a myopic provision puts the Medicare beneficiary in an untenable position and forces them to make a choice which they should not have to make. We recommend a restructuring of this proposal to eliminate the need for these kinds of decisions.

Other Services

Two other issues regarding qualified plans that must be addressed are those of coverage of preventive care service and mental health.

We commend Representative Gephardt and Senator Hatch for their foresighted approach in recognizing the need for and the cost-effectiveness of preventive care services as part of any qualified health plan. The inclusion of such services is one of the most important aspects of the bills under consideration and we urge that any preventive program include a broad range of services such as those specified in S. 139.

Further, we note that H.R. 850 specifically excludes items and services related to mental or emotional illness or chemical dependency. We feel that such a specific exclusion is totally unreasonable and that a minimum level of mental health services should be included as part of basic health care services.

Summary

H.R. 850, S. 139, and S. 433 contain innovative competition-based concepts that may help in our continuing attempts to improve our national health care delivery system. We urge, however, that careful attention be given to improving, not just altering, the health care system by ensuring adequate coverage requirements, maintenance of quality, and freedom of choice in the service setting.

The objective of any health care approach -- including a competitive one -- should not be solely to reduce health costs, but should continue to improve the accessability and availability of quality health care to all consumers in the most cost-effective manner.

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Chairman JACOBS. Thank you.

STATEMENT OF PAUL GILBRIDE, PRESIDENT, GILBRIDE INSURANCE, INC.

Mr. GILBRIDE. Mr. Chairman and members of the subcommittee, I am Paul S. Gilbride, president of Gilbride Insurance, Inc., a local insurance agency that offers a wide range of insurance services, including extensive health care insurance programs.

I am pleased to be given the opportunity to appear before you today to testify on the crucial need for occupational therapy and other rehabilitation services to be included in the minimum coverage requirements of any health insurance plan, including the private qualified health plan you are discussing in these hearings.

I feel particularly qualified to address this issue due to the combination of my 30 years experience in group health insurance matters, and my illness that required rehabilitation services.

My remarks will focus on occupational therapy and physical therapy and the other rehabilitative services that we feel should be included in this plan.

On July 29, 1976, I suffered a massive stroke followed by brain surgery 2 weeks later. The stroke left my left side completely paralyzed. I was under constant treatment by professional occupational therapists since the first day of my stroke.

They have taught me the daily living habits normally taken for granted; that is, how to move, eat, sit up, stand, more to and from my wheelchair, and walk.

In other words, I was retaught every function that goes with learning to function for myself.

Therapy was performed on my leg, arm, shoulder, elbow, wrist, and hand.

I have been substantially rehabilitated in the use of my leg and arm, and am continuing progress on my hand and fingers.

It should be noted that soon after my stroke I was informed that I would not be able to continue working. Yet, after receiving proper rehabilitation, I have returned to operate my business on a full-time basis, and to continue the employment of my personnel in my office. I am sure no one here today would disagree about the value of the rehabilitation I have received.

I found out that if you asked a lot of people what was in their health insurance contract, they couldn't tell you. We never look at that until we get an illness ourselves or in our families. Do you know that occupational therapy on a stroke victim for any Government employee on most of the carriers you have is not now covered? That is something to think about.

That is what I want to talk to you about.

There were a lot of people in the hospital that had strokes. By the way 750,000 people have strokes every year. Of those 750,000, the ones who survive, this is one of the most costly medical illnesses there is.

I think my bills now run to about $70,000 in the last 5 years. How many of us can afford that today? That is why I think it is so important that these services be put into your basic contract.

I am fortunate. I have been able to get these services and they were paid for me. I am back to work, running my business. I am employing people. If I didn't have it, I would have been sitting at home. I would be on social security.

I think it is so important that we get these services put in a basic contract.

I hear employers tell me every day the cost of hospitalization is going through the ceiling. I am saying to you I know how you can solve a lot of these problems. Give them some basic covearge on out-patient service and cut the costs from $300 a day to $68 a day.

This is what we are talking about, cost containment. Whether Uncle Sam is involved in the situation or the private sector is involved in it.

Management is telling me I can't afford to pay these big hospital costs.

The employees say I can't afford it either because taxes are so high.

That is why I am so strongly saying I hope that you will put something in the bill that will give some of these rehabilitation services to the people that need them so badly.

Thank you.

Chairman JACOBS. Thank you very much.

[The prepared statement follows:]

STATEMENT OF PAUL S. GILBRIDE, PRESIDENT, GILBRIDE INSURANCE, INC., WASHINGTON, D.C.

Mr. Chairman and members of the subcommittee, I am Paul S. Gilbride, President of Gilbride Insurance Inc., a local insurance agency that offers a wide range of insurance services, including extensive health care insurance policies.

I am pleased to be given the opportunity to appear before you today to testify on the crucial need for occupational therapy and other rehabilitation services to be included in the minimum coverage requirements of any health insurance plan - including the private qualified health plan you are discussing in these hearings. I feel particularly qualified to address this issue due to the combination of my thirty years experience in health insurance matters and my illness that required rehabilitation services. My remarks will focus on occupational therapy, but I feel equally strongly about the value of, and the need for, all rehabilitative services.

On July 29, 1976, I suffered a massive stroke followed by brain surgery two weeks later. The stroke left my left side completely paralyzed. I was under constant treatment by professional occupational therapists since the first day of my stroke. They have taught me the daily living habits normally taken for granted; that is, how to move, eat, sit up, stand, move to and from my wheelchair, and walk. In other words, I was retaught every function that goes with learning to function for myself. Therapy was performed on my leg, arm, shoulder, elbow, wrist and hand. I have been substantially rehabilitated in the use of my leg and arm, and am continuing progress on my hand and fingers. It should be noted that soon after my stroke I was informed that I would not be able to continue working. Yet, after receiving proper rehabilitation, I have returned to operate my business on a fulltime basis, and to continue the employment of my personnel in my office. I'm sure no one here today would disagree about the value of the rehabilitation I have received.

More important to the Subcommittee today, however, is what I learned about rehabilitation coverage while recuperating from my stroke. I was fortunate enough to have broad coverage in my own personal policy but discovered, to my surprise, that others in my situation had limited coverage and, in some cases, had no coverage whatsoever outside an inpatient hospital status. This is neither adequate basic medical care nor cost-effective. Upon returning to work, I ran a check of the health insurance policies that I carry to determine their rehabilitation coverages, and I now insist that all health policies issued by my office contain adequate rehabilitation coverage in all settings, including those outside the hospital. Rehabilitation services are obviously needed after a hospital stay.

With the cost containment pressures of today, expensive hospital stays should obviously be as short as possible. Yet, many policies will cover rehabilitation services for patients only in the hospital. This results in patients being held in, or returned to, an expensive inpatient status just to receive rehabilitation services. This is certainly not cost-effective and I strongly urge you to allow, and indeed encourage, the coverage of such important services in all appropriate settings, whether it be the hospital, the home, a rehabilitation facility or as an outpatient.

Another important point to make is that the complex nature of most health insurance policies makes it virtually impossible for the layman to fully understand the coverage requirements. In fact, I must admit that I, a health insurance expert, was not precisely aware of the nature of occupational therapy nor of the precise coverage of occupational therapy and other rehabilitative services in all settings. This is why I insist that adequate basic rehabilitation protection in all settings be included in the policies I sell. Its only when you need the service that you discover that you may not be covered. I wonder how many in this room today realize, for example, that the Blue Cross/Blue Shield and Aetna plans for Federal Employees do not cover outpatient occupational therapy? To that degree of specificity, I doubt that many would know. The point is, most people would not know, and I feel it incumbant on those responsible for establishing minimum health plan standards to include basic rehabilitation services in all settings, as minimum protection.

My message is really quite simple. As one who has suffered a stroke, I can attest to the need and value of occupational therapy and other rehabilitative services. As one well versed in the intricacies of health insurance, I can assure you that most consumers would not be able to differentiate between plans based on rehabilitative services. Rehabilitative services are clearly necessary and their availability in all settings is very cost-effective. Based on the above, I urge you to include rehabilitative services in all settings as part of the minimum basic health care services of any qualified plan.

STATEMENT OF KENNETH L. ADAMS, WASHINGTON REPRESENTATIVE, NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK

Mr. Adams. I am Ken Adams, Washington representative of the National Federation of Societies for Clinical Social Work. I do not intend to go through my written statement. I ask that it be included in the record.

Nor do I intend today to go into the matter which I expect you will hear a great deal about on Friday when some of the mental health provider groups and mental health associations come to speak to you about the whole question of extent of mental health services.

I didn't want to leave that unmentioned. Clinical social workers are the single largest provider group in the mental health community. They are one of the four core disciplines providing mental health services to individuals and groups around the country. We strongly feel and have urged for years in the medicare program and the Federal employee program and private insurance programs that more attention be paid to mental health needs, that more recognition be given to the integration of mental and physical health, to the cost savings overall that can be accomplished by funding mental health services at an appropriate level.

Let me pass all of that and touch, if I may upon an issue which I have heard very little about today but which intrigues me. I think it is something that needs to be taken into consideration. The clinical social workers I represent and their patients have been the victims of the anticompetitive aspects of the past and present health insurance reimbursement structures including, very much including medicare.

They have tended to preclude consumers from fully utilizing nonphysician providers of health care services. There are institutional biases in the health care delivery system and in the insurance reimbursement system. In the past we have seen those in terms of institutional care versus out-patient care.

It was addressed by several of the witnesses earlier today. We see it in terms of physician versus nonphysician providers all the time. What this suggests to me when you look at the macroeconomic issues that you have been focusing largely on today—and I look at one little piece of that that I am very familiar with, I think sometimes you can learn from the microeconomics.

The experience of the physician providers and their patients illustrates what to me is a fundamental limiting factor in the basic concept here of providing incentives for competition, because a lot of the discussion today about the ability of consumers of health care services to shop wisely for services, given a free choice, assumes that they are given a free choice of services, and we have to keep in mind that in large measure there is an interloper here, a very significant interloper, the insurance industry.

What we are really talking about is encouraging competition among insurance carriers to offer competing plans, but that is a fundamental limiting factor, because how they decide what kinds of plans they are going to offer and how they are going to compete with one another inevitably restricts the choices of the individual consumers to get the range of health care services that they might choose if given a truly free option.

The example that you gave earlier, Mr. Chairman, in talking about the individual who may go to a particular hospital that charges more because that is where their chosen physician practices, they don't have an unfettered choice.

It reminds me of an analogy to the much embattled automobile industry. I suppose if the U.S. Government had erected trade barriers to foreign imports years back and really limited my and your and every American consumers' automobile choice to automobiles manufactured in this country, we would have ended up in a very different place in terms of the ability of consumers to buy cheaper cars, smaller cars, compact cars, and fuel efficient cars.

Detroit was always presumably able in a competitive sense to meet that demand and make more money by selling more cars of a different kind, but didn't do it.

The free market only operates to the extent that the competitors are intelligent, are acting out of a profit motive which is informed and unencumbered by tradition, narrow perceptions, old ways of doing things, comfortable ways of doing things, lack of creativity and so on.

All of these things are true in the health insurance industry. There are traditional ways of channeling services. Unfortunately for the nonphysician providers, the hospitals and the physicians have been traditionally the principal providers of health care services.

The insurance industry is used to doing things that way; they like to do things that way; they have all kinds of structures that depend upon that. They do not respond creatively to the availability of many services through nonphysician providers where the per unit cost of providing the services may be cheaper; it may be more appropriate, and so on.

That is the issue that I am interested in as it affects the clinical social workers. As I indicated in my written—in my prepared statement, there are a number of State legislatures now that are enacting what are called freedom of choice laws which say that we are not going to tell you you must cover this kind of service; that is up to you; but if you cover the service, and say you are making it available to the people who buy your policy, you may not require the covered individual to get that service from only one kind of provider. They must be permitted to get it from any provider who is permitted under state law to provide that service. If that is a clinical social worker, you cannot create a physician monopoly in that situation.

I would hope, as I said in my prepared statement, that Congress will incorporate that concept into any legislation that emerges in this area, and to the extent that minimum standards are set for qualifying group insurance plans, whatever specific services are to be included in a qualified plan, the plan should be prohibited from discriminating among qualified nonphysician providers who are authorized by State law to provide, to render the services that are covered in the plan.

Thank you.

[The prepared statement follows:]

STATEMENT OF KENNETH L. ADAMS ON BEHALF OF THE NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to testify today on behalf of the National Federation of Societies for Clinical Social Work, on the subject of stimulating competition in the financing and delivery of health care services.

The National Federation is a federation of state organizations, whose members are clinical social workers (also known as psychiatric social workers). Clinical social workers around the country provide mental health services to individuals and groups in a variety of settings, including hospitals, private and public mental health clinics, health maintenance organizations, and in private practice.

Historically the most significant obstacle to cost-effective delivery of mental health services has been restrictive insurance reimbursement practices which tend to grant a monopoly to physicians as reimbursable providers. The federal Medicare program is one of the most important examples, simply because so many private and public health insurance programs are influenced by the scope of Medicare coverage.

It has long been understood that the structure of health insurance reimbursement has a significant impact on the distribution and delivery of health care services. These hearings, and the pro-competition legislation underlying the hearings, reflect that widely shared understanding. By now there are very few individual consumers of health care services who are self-insured. As a result, consumer freedom of choice is constrained by insurance carrier decisions as to which services and which providers will qualify for reimbursement. Too often that has meant that only physicians are authorized to provide covered services which could be provided equally well (and in some instances better) by less expensive and more widely available non-physician providers.

A growing number of state legislatures have enacted freedom of choice laws in the mental health area, requiring that insurance policies which provide coverage for mental health services permit the consumer to choose among the various kinds of qualified providers -- psychiatrists, psychologists and clinical social workers.

These state laws permit the insurance carrier to decide what kinds of services it wishes to cover. But once a decision is made to include coverage for outpatient psychotherapy, for example, the insurance carrier is not free to limit reimbursement to physicians when there are non-physician providers who are well qualified by education and experience and who are authorized by state law to practice psychotherapy.

I would hope that Congress will incorporate that concept in any new legislation, to the extent that minimum standards are set for qualifying group health insurance plans. Whatever specific services are to be included in a qualified plan (either because Congress mandates their inclusion or because the carrier elects to offer coverage), the plan should be prohibited from discriminating among qualified providers who are authorized by state law to render the services in question.

The 1978 President's Commission on Mental Health specifically recommended that public and private health insurance programs should provide for mental health care in the "most appropriate and least restrictive setting, and the consumer should have a choice of provider and provider systems." The Commission urged that financing of mental health care services be restructured so that "payment is based upon the appropriateness of care, not the discipline of the provider." These recommendations grew out of a comprehensive study of the weaknesses in our mental health care delivery system, including the ways in which restrictive insurance reimbursement mechanisms distort the cost-effective allocation of provider resources.

Curtailing the physician monopoly over mental health care insurance reimbursement will permit consumer choice and market competition to define the mix of providers and the cost of their services, rather than steering most psychotherapy outpatients (as today) to psychiatrists, the most expensive and least widely available provider group.

Clinical social workers are well qualified, by education and experience, to serve the mental health care needs of their patients. In fact they provide the largest portion of services in federally funded community mental health centers. It is costly and counterproductive for clinical social workers to have to refer patients to psychiatrists or more expensive inpatient settings, in order for the patient to qualify for health insurance reimbursement. I am hopeful that Congress will keep in mind, as pro-competition legislation is formulated, the importance and value of encouraging competition among the mental health disciplines by allowing consumers to choose freely among the various qualified providers of mental health services.

Chairman JACOBS. Mr. Gephardt?

Mr. GEPHARDT. Thank you, Mr. Chairman.

Thank you for your testimony. There is a thread, I guess, that runs through your testimony, and that is that you feel either the way a particular group delivers a service or the track record of that group would indicate that we should somehow mandate that service to be included.

I hope you understand that in H.R. 850 there is no preclusion of any kind of service. We do have very minimal standards in the case of the working population, just a maximum amount that they can be out of pocket.

We have gone to great lengths to not say what must be included in a qualified plan and have left that to the marketplace.

I guess my question to you is, if that is the case in the bill we finally pass—if we pass a bill—do you think the services that you have talked about this morning would be competitive and would be included in plans; and, if so, why do you believe that, because of quality, because of price or what?

Mr. ADAMS. I suspect all of us might want to address that.

I would like to address that in terms of mental health services. I am a consumer. I belong to a group that is insured with a well known insurance carrier. We have tried very hard to get that carrier to cover non-physician provider services in mental health. Unsuccessfully, because they have a nationwide plan and it has always been done this way and they only pay physicians and they won't do it any other way.

Consumer demand is not necessarily enough. We are not operating in a pure market here, particularly in the area of mental health service. Whether we like it or not, there is still a significant stigma attached that makes many consumers reluctant to come forward and articulate a demand for services; to go to their insurance companies, to their employer groups, to their unions and demand these services, thereby saying I am somebody who wishes to utilize them and mental health services particularly is an area where it is very difficult to entertain the notion of a true free market in which consumer demand is openly expressed and responded to because it has not worked that way.

Ms. SCOTT. I would like to support that position and say that we receive frequent telephone calls in our office from distressed consumers who have found out that their particular services are not covered under this policy. They have tried to get it covered. For various reasons the insurance company will say:

> We can't do that because it may have some effect on the rate and we can't change our rate until we go to the rate commission and ask for an increase, and we wouldn't want to do that for one instant; we would rather wait until we have several changes to go to the insurance commission with.

We have consumer demand that has not always brought about inclusion in programs in insurance programs, but to the extent that there are no barriers placed in a particular bill against their being included, at least there would be the chance to have them included in packages.

We are concerned that there may be some arbitrary restrictions placed on it which would make that impossible.

For example, when I was talking about settings, right now there are specific restrictions in medicare and medicaid on a setting where a service can be provided.

So there is no way you can market the service in that setting.

Mr. ADAMS. Let me also say, Congressman Gephardt, under the present situation there is no bar to employers offering choices of competing plans. There is no bar to insurance companies to do exactly what we are trying in this legislation to give them incentives to do.

Legislative proposals reflect the judgment that unless you provide affirmative incentives, sometimes the initiative is not taken. To say we will give them incentives to do this, we will leave them free to do the other, but not give them the same incentives, by mandating it, by encouraging it, it does reflect a statement I think you have to expect there will be a correlative response to that.

What is mandated will be provided and what is not mandated, there will be less incentive to go out and offer or to look to offer.

Ms. SCOTT. Mr. Gephardt, you do have some benefits in your bill. What may seem to be a minimum could become a ceiling. Those could be the only benefits provided in a plan, if that is all that is mandated.

Mr. GEPHARDT. I don't know of any benefits we provide for except for the out of pocket costs.

Ms. SCOTT. You have hospital services, you have skilled nursing and home care service, but only for the aged and disabled.

You specifically exclude mental health benefits.

Mr. GEPHARDT. What we do is, medicare has tried to pick up where the medicare law is now. We don't believe that you can just cut that loose and say that there is no elemental set of benefits from medicare.

For everybody in the working population, the only thing that is required is the $2,900 floor.

Ms. **Scott**. Well, it was not clear to us that the medicare benefits were the minimum. Perhaps that is our error. We read the section of the bill that described the services and interpreted that as the minimum benefit for any qualified plan.

Mr. **Gephardt**. I don't think that is the case. We can talk about it.

Ms. **Scott**. Thank you.

Mr. **Gephardt**. Thank you, Mr. Chairman.

Chairman **Jacobs**. The committee is grateful for your testimony and your contribution to the record and, Ms. Scott particularly to you for representing so many groups all in one fell swoop. We appreciate that. Thank you.

Ms. **Scott**. Thank you.

Chairman **Jacobs**. Our final testimony today will come from Mr. Edwin Kenrick, president of the American Chiropractic Association, and Bruce Nordstrom, executive vice president of the International Chiropractors' Association.

Mr. **Kenrick**. I would like to introduce Mr. Rosenfeld, our Washington counsel. I am Dr. Kenrick. This is Dr. Bruce Nordstrom. This is counsel for the International Chiropractors Association, Mr. McQueeney.

JOINT STATEMENT OF BRUCE E. NORDSTROM, D.C., EXECUTIVE VICE PRESIDENT, INTERNATIONAL CHIROPRACTORS ASSOCIATION, AND EDWIN M. KENRICK, D.C., PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION, ACCOMPANIED BY HARRY ROSENFIELD, COUNSEL, AMERICAN CHIROPRACTIC ASSOCIATION

Mr. **Nordstrom**. Thank you for this opportunity to share with the subcommittee our feelings on procompetitive health insurance proposals. We would like to highlight our general concerns with this approach and Dr. Kenrick will address our specific recommendations.

We hope our full testimony will be placed in the record.

The International Chiropractors Association and the American Chiropractic Association together represent the 23,000 practicing chiropractors nationwide.

Chiropractors had approximately 122.5 million patient visits in 1979, generating over $1.3 billion in practice revenues. Chiropractic is a licensed health care profession in all 50 States and chiropractic services are authorized under a wide variety of Federal programs including medicare and medicaid.

As a major nonmedical provider group, we have long been interested in efforts to improve competition in the health care industry.

In past years before this subcommittee, we have testified in support of a comprehensive national health care insurance scheme. We continue to feel that many of the inequities in our health care system can only be solved through a comprehensive restructuring of that system.

The procompetition bills have forced many of us in the health care community to reexamine how we are going to achieve that goal in light of the current political and especially fiscal realities.

The history of our profession's successful efforts to establish itself in the face of organized medical opposition is a matter of common knowledge.

We therefore have first hand experience with many of the anticompetitive features of the current health care system.

We strongly support any effort to increase competition among health care practitioners and health care insurers. We see much potential benefit to chiropractors and the patients we serve in the procompetition approach both in terms of quality and cost of health services.

At the same time we do have concerns with the means selected by these bills to achieve increased competition and cost consciousness.

The procompetition bills build in cost incentives into the health care system in one primary way: by encouraging cost consciousness on the consumer's part. We think the more appropriate focus for increasing cost consciousness should be on those who account for the vast majority of expenditure decisions in the health care industry; that is, the providers and the health care insurers.

It is simply not known what motivates consumers' selection of health care insurers. Our experience has been that consumers will choose the health services they find most beneficial, regardless of the reimbursement difficulties involved. Despite the problems chiropractic patients have faced over the years in obtaining payment of chiropractic services, patients continue to seek our chiropractic care at an increasing rate.

Even assuming that cost incentives will govern consumer selection of insurance and health services, this consumer cost consciousness must translate into cost consciousness on the part of providers and health insurers who will in turn offer innovative health plans and alternative less expensive forms of health services.

Our experience has unfortunately shown the opposite.

Medical domination of the health care industry and health insurers may well work as it has in the past to prevent the introduction of innovative delivery systems and alternative health care services no matter how cost effective they may be.

For example, worker compensation studies in over half a dozen States have shown chiropractic care to be the most cost effective form of treatment for back and related injuries. Despite this, chiropractors and other alternative providers experience difficulties in securing reimbursement for their services from insurers, even where reimbursement has been mandated by State law.

Similarly, medical domination of HMO's has limited HMO utilization of nonmedical, cost effective health services. We think the key to lowering health care costs is a truly competitive market for health professional services.

The procompetitive approach, however, encourages provider competition in a most indirect way. We must question whether this approach by itself will alter many of the features of our current system which inhibit true competition between providers, especially the institutional bias of the health industry against innovative delivery and against nonmedical health care providers. Specific safeguards must be built into the legislation if the current focus of the health care industry is to be shifted.

Dr. Kenrick will address our specific recommendations in this area.

Mr. **Kenrick**. Thank you, Dr. Nordstrom.

Gentlemen, we urge that the following recommendations be incorporated into any procompetition legislation the Congress may ultimately adopt.

Looking at freedom of choice as a general matter, any health legislation should mandate freedom of choice for the consumer in the selection of his or her health care provider.

Antitrust enforcement. Given the monopoly characteristics of much of the health care industry today, vigorous antitrust oversight by appropriate arms of the Federal Government is essential to increasing competition among providers.

We, therefore, support the approach of sections 209 and 210 of House bill No. 850.

The benefits. Legislation should therefore mandate a minimum standard of coverage below which plans cannot drop.

Minimum benefit levels must be specified so that increased cost consciousness of health insurers does not lead to a decrease in the number of health services covered, particularly in the lower cost plans.

We, therefore, support Senate bill No. 433 and Senate bill 139 mandating that at least current medicare services be the minimum allowable.

The role of medicare and of medicaid. A voucher plan, whether enacted by itself or as part of the larger procompetition plan, must have the following features:

First of all, those services currently mandated under medicare must continue to be a mandated minimum under any voucher proposal. We support adoption of an HMO option for medicare. Mandated medicare services must be clearly enunciated to the beneficiaries so that alternate health care providers will not be ignored by the HMO's.

Medical domination of HMO's have often prevented enrollees from obtaining chiropractic care despite the fact that chiropractic is a mandated medicare service.

Health plan options. We support the requirement of Senate bills 139 and 433 that at least three health plan options of different carriers be offered to employees. We see this as a minimum and, in fact, would hope that more options are offered to employees.

We support mandating a prepaid plan option to insure that alternate delivery be allowed to compete with more traditional health insurance plans.

However, given the traditional medical domination of HMO's and prepaid plans, we urge that participation of chiropractors as well as other nonmedical producers be mandated.

To insure that health care choices are offered and anticompetitive practices are curtailed, the following recommendations should be incorporated into this legislation:

Mandate the availability of alternative services. Chiropractic has been shown to be a cost effective alternative which provides savings to consumers.

As a basic principle, every Federal health plan should authorize chiropractic care. HMO's should incorporate chiropractic services, especially those enrolling medicare beneficiaries.

Patients should be adequately informed of the availability of alternate health care services, including chiropractic.

Any medicare voucher system should mandate patient freedom of choice to use those health care services authorized by State law.

Antitrust enforcement by the Federal Government must be maintained. The chiropractic profession salutes you for your efforts in developing procompetitive influence in the health care industry.

Gentlemen, thank you very much.

[The prepared statement follows:]

STATEMENT OF BRUCE E. NORDSTROM, D.C., EXECUTIVE VICE-PRESIDENT, INTERNATIONAL CHIROPRACTORS ASSOCIATION, AND EDWIN M. KENRICK, D.C., PRESIDENT, AMERICAN CHIROPRACTIC ASSOCIATION

INTRODUCTION

The International Chiropractors Association and the American Chiropractic Association are grateful for this opportunity to share with the U.S. House Ways and Means Subcommittee on Health the concerns of the chiropractic profession regarding the proposals to stimulate competition in the financing and delivery of health care. Our associations together represent the 23,000 practicing chiropractors nationwide. It is a pleasure to be with you today.

As a major non-medical health care provider group, chiropractors have long been interested in efforts to improve competition in the health industry. The history of our profession's successful efforts to establish itself in the face of organized medical opposition is a matter of common knowledge. We thus have first hand experience with many features of the health care system which stifle competition between competing provider groups and which impede the development of innovative health care delivery. We therefore strongly support any effort to effectively increase competition among the various sectors of the health care industry. We are confident that competition between health practioners and health insurers will greatly benefit the health care consumer, in terms of both the quality and the cost of health services.

In previous years before this Subcommittee, chiropractors have testified on the various national health insurance bills proposed in past years in the Congress. As with many groups who have testified today, we have supported a national health insurance scheme comprehensive in terms of population and benefits coverage. We remain committed to the goal of quality, affordable health care for all Americans. We continue to feel that many of the problems and inequities in our health system--especially the problem of soaring inflation in the health industry---can only be solved through a comprehensive rather than piecemeal restructuring of that system. The means to achieve this goal must, however, be examined in light of existing political and fiscal realities. The "pro-competition" bills thus far introduced in the Congress have forced that reexamination.

We see much potential benefit both to chiropractors and the patients they serve in the "pro-competition" approach to health care. We must emphasize "potential", since many of the features of this legislation, particularly the sweeping changes advocated by H.R. 850, are untested and highly speculative. At the same time, we have serious concerns with the means selected by these bills toward achieving increased competition and cost-consciousness in the health industry.

CHIROPRACTIC: PARTNER IN OUR HEALTH CARE SYSTEM

Before focusing on the financial condition of the health care industry, the Medicare voucher concept, and other areas of inquiry a review and assessment of chiropractic's current role in the health care system is appropriate. Almost all major federal government health programs include chiropractic services today.

Federal policy has been clear in regard to chiropractic's partnership role in the health delivery system. The federal government recognizes chiropractic in Medicare, Medicaid, Vocational Rehabilitation, federal and postal employees workers compensation, the federal employees health benefits program, the Health Professions Act, the Longshoremens and Harbour Workers Act, and under the Internal Revenue Code chiropractic health care as a "medical" deduction. The U.S. Department of Education has recognized the Council on Chiropractic Education as the official accrediting body for the chiropractic profession on an equal basis with other professions. The import of the foregoing list is that the intent of the Congress is clear: a recognition and integration of the chiropractic profession as a partner in the nation's health care system.

On the state level chiropractic's role is equally incorporated into the health care system. All fifty states, plus the District of Columbia and Puerto Rico, license and officially recognize chiropractors. All fifty states authorize their services as part of their workmen's compensation programs. Over three-fifths of the states, representing some seventy per cent of the nation's population, require inclusion of chiropractic services under all commercial health and accident policies written in those states.

PRO-COMPETITION: WILL THIS APPROACH WORK?

While there has been much public debate as to why health care costs seem increasingly out of control, much health care inflation can, we think, be attributed to the anticompetitive aspects of much of the health care industry. Certainly the insulation of the consumer from the true costs of health care through our reimbursement system has contributed to the consumer's lack of cost-consciousness in selecting his or her health care. A more important factor, however, has been the lack of such cost-consciousness on the part of those who account for the vast majority of expenditure decisions in the health industry--that is, providers and health insurers. Attempts to induce sensititivity to health care costs should focus on those sectors of the industry that most directly control utilization and reimbursement levels.

Incentives to control costs must be built into a health care system currently lacking such incentives. The pro-competition bills thus far introduced in the Congress attempt to achieve this primarily through encouraging cost-consciousness on the consumers part--by limiting the tax-free treatment of employer contributions to health insurance, through tax rebates for consumers choosing less expensive insurance coverage, and by extensive consumer cost-sharing.

Yet, there is simply no definitive answer as to the significance of cost as a motivator for consumer selection of health care or health insurance. With insurance coverage, the experience of our nation's elderly with Medicare supplemental insurance indicates that consumers are willing to pay the price for broad, comprehensive insurance coverage, with cost being a relatively weak motivator. Similarly with health care services, the experience of the chiropractic profession over the years has shown that the consumer will choose the health services he finds most beneficial regardless of the reimbursement obstacles placed in his path. Despite the difficulties chiropractic patients have faced over the years in obtaining payment for chiropractic services from their insurers, patients continue to seek out chiropractic care at an increasing rate.

Nevertheless, research does indicate that the introduction of financial incentives--particularly consumer cost-sharing---does in fact work to induce consumer cost-consciousness in the selection of health care and health insurance. Whether this will effectively translate into cost-consciousness on the part of health insurers and providers is, however, questionable. It has been estimated that 70% of health expenditure decisions rest with providers and not consumers. A key factor in lowering health care costs nationally, therefore, is a truly competitive market for health professional services.

The traditional pro-competitive approach, however, encourages provider competition in the most indirect way. It assumes that consumer cost-consciousness will in fact induce significant competition--in terms of benefits and cost--among health insurers. To remain competitive in the marketplace, health insurers will in turn be required to effectively control costs by offering innovative health plans and by encouraging the provision of alternative health care services.

This rationale is at this point highly speculative. In fact, past experience in the health industry has shown exactly the opposite to be the case. Medical domination of health care delivery and of health insurers may work, as it has in the past, to prevent the introduction of innovative delivery systems and alternative health services. Health insurance plans have been reluctant to reimburse for services of chiropractors and other non-medical health providers even where such care has proven to be cost effective.

For example, worker compensation studies in over a half-dozen states have shown chiropractic to be a cost-effective form of health care. The studies measured the cost-effectiveness of chiropractic services versus medical services. The studies used individual state records to determine that chiropractic returned injured workdrs with comparable injuries back to the job faster and at less cost than treatment by M.D.'s Case studies have revealed that chiropractic care reduces treatment costs, reduces compensation costs, reduces employee time losses, and reduces worker disability in comparison with other types of care for the treatment of back and related injuries.

Thus, despite the cost-effectiveness of the care they provide, chiropractors and other alternative providers experience difficulties in securing reimbursement for their servives from insurers even where such reimbursement has been mandated by state law. Similarly, while the development of HMO's as an alternative to fee-for-service delivery has in many instances increased competition with traditional health insurance plans, medical domination of HMO's has limited HMO utilization of non-medical, cost-effective health services. We must therefore question whether the pro-competition approach by itself would alter the "institutional" bias of the health industry against non-medical health care providers.

In sum, the goal of the pro-competitive approach is to lower health care costs by increasing competition among providers and by encouraging alternative, less expensive forms of health care. We agree that these factors are the key to containing soaring health care costs. At the same time, this approach attempts to ensure that all Americans have access to adequate health care services. If these goals are to be reached, we urge that the following recommendations be incorporated into any pro-competition legislation the Congress may ultimately adopt.

FREEDOM OF CHOICE

As a general matter, any health legislation should mandate freedom of choice for the consumer in the selection of his or her health care provider. Pro-competitive legislation must assure that health care consumers have the right to choose any state licensed health care practitioner under each plan, thus guaranteeing the availability of competitive and low cost health care.

Section 302(b) (2) of H.R. 850, for example, provides for pre-emption of state laws restricting the provision of specified health services to only a particular type of health professional. While we have concerns as to so sweeping a pre-emption of an area traditionally regulated by the states, we strongly support its' encouragement of the provision of health services by non-traditional providers. This section would guarantee the opening of the health services market to providers that have often been excluded.

ANTITRUST ENFORCEMENT

Given the monopoly characteristics of much of the health care industry today, vigorous anti-trust oversight by appropriate arms of the federal government is essential to increasing competition among providers. This would ensure that the health care market in fact moves toward diversification and competition, especially in the initial years of these programs. We therefore support the approach of Sections 209 and 210 of H.R. 850. We urge that any legislation adopted specifically mandate aggresive antitrust enforcement by the federal government.

BENEFITS

Whatever pressure pro-competition legislation might bring to bear on health insurers to contain costs will greatly affect the health services coverage offered by these plans. The goal of comprehensive, quality health care must be adhered to in any specification of the particular services health insurers must cover.

Legislation should therefore mandate a minimum standard of coverage below which plans cannot drop. Minimum benefit levels must be specified, so that increased cost-consciousness of health insurers does not lead to a decrease in the number of health services covered, particularly in the lower cost plans. We therefore support S. 433's and S. 139's mandate that at least current Medicare services be the minimum allowable.

At the same time, we would support the expansion of mandated benefits to focus on preventive and other ambulatory health services which would deter utilization of hospital services, the most expensive component of health care costs. Such benefits must be provided if the current focus of health insurance toward acute care and hospital services is to be shifted. We urge that chiropractic care, as well as other forms of non-medical care, be specified as a mandated service.

ROLE OF MEDICARE AND MEDICAID

A voucher plan, whether enacted by itself or as part of a larger pro-competition plan, must have the following features. First of all, those services currently mandated under Medicare must continue to be a mandated minimum under any voucher proposal. The Medicare voucher plan of H.R. 850, for example, in failing to detail with any specificity the health services to be required in "qualified health plans", would appear to leave the door open for plans offering less than currently mandated Medicare services in an effort to control costs.

We support adoption of an HMO option for Medicare. According to earlier congressional testomony, those demonstration projects which have allowed Medicare beneficiaries to enroll in HMO's have proven to be satisfactory to the Medicare population. In testimony before the U.S. Senate Finance Subcommittee on Health, we expressed our support for the concept of HMO's yet we tempered our remarks with reservations about the operation of such a system without certain checks. Mandated Medicare services must be clearly enunciated ot the beneficiaries so that alternate health care providers are not given short shrift by HMO's. Medical domination of HMO's have often prevented enrollees from obtaining chiropractic care, despite the fact that chiropractic is a mandated Medicare service.

We must express our reservations, however, with the "voucher' concept as a proposed solution to cost-escalation in the Medicare and Medicaid programs. This approach again assumes that Medicaid and Medicare beneficiaries will in fact select health insurance and health services on the basis of costs and informed choice, thereby forcing insurers and health practitioners to lower costs in order to remain competitive. If this is doubtful even with the average consumer, it is even more doubtful when discussing the Medicaid or Medicare population. These groups, of course, have health care needs not shared by the general population. The experiences of Medicare beneficiaries with "Medigap" coverage have shown that the elderly are particularly vulnerable to the purchase of fraudulent and unnecessary health insurance. Fear of health care bills has, instead, led many of the elderly to purchase unnecessary insurance, with cost obviously of little effect in their decision-making. Before a voucher system is adopted, we urge that additional data be collected as to the practical effects of such a system.

HEALTH PLAN OPTIONS

Mandating that employer's offer multiple plan options to employees has immense potential both to stimulate innovative health delivery and to increase competition among health insurers. We support the requirement of S. 139 and S. 433 that at least three health plan options of different carries be offered to employees. We see this as a minimum, and in fact would hope that more options are offered to employees. A minimum number must, however, be specified in the legislation to ensure that at least a minimum variety of plans be offered in areas traditionally "underserved" by insurers--low-income rural and urban areas.

We support mandating a pre-paid plan option to ensure that alternative delivery be allowed to compete with more traditional health insurance plans. This would speed along development of HMO's and other prepaid plans in those many areas of the country presently without this option. However, given traditional medical domination of HMO's and pre-paid plans, we urge that participation of chiropractors, as well as other non-medical providers, be mandated.

SUMMARY

The debate concerning a restructuring of our national health care system and its financing has already consumed a decade of legislative proposals. The chiropractic profession has always expressed its support for a truly competitive system and patient freedom of choice to choose their health care provider. To ensure that health care choices are offered and anti-competitive practices are curtailed, the following recommendations should be incorporated into this legislation:

O Mandate the availability of alternative services. Chiropractic has been shown to be a cost effective alternative which provides savings to consumers.

O As a basic principle every federal health plan should authorize chiropractic care.

O HMO's should incorporate chiropractic services, expecially those HMO's enrolling Medicare beneficiance. Patients should be adequately informed of the availability of alternative health services, including chiropractic.

O Any Medicare voucher system should mandate patient freedom of choice to use those health care services authorized by state law.

O Antitrust enforcement by the federal government must be maintained. Absent vigorous antitrust oversight, those interests currently dominating health delivery may well defeat the objectives of any pro-competition legislation enacted.

Chairman **Jacobs**. Thank you.

Mr. Gephardt?

Mr. **Gephardt**. Thank you for your testimony.

I just wanted to ask if you are pleased or not pleased with the provisions in H.R. 850 that do not preclude plans from offering services like chiropractic services if they want to do that?

Mr. **Kenrick**. My profession doesn't feel that that is enough, Congressman.

Mr. **Gephardt**. You would rather the bill say that chiropractic services must be included in any package?

Mr. **Kenrick**. We feel this has to be mandated. It has been done this way for years. It simply does not work because of the traditional—and this was brought up by other people testifying—because of the traditional trends in the market.

Mr. **Gephardt**. Don't you feel if we begin mandating each and every kind of service that has to be included there is not going to be a lot of competition because we will have defined, if we include all the services that are being asked to be included as mandatory, and that includes dentistry, psychiatrists, and a number of other services, that we will pretty soon have a package that exceeds the UAW package in terms of richness and we won't have much competition occurring at all?

In fact, we will have the health care costs in this country above what they are now in terms of running ahead of inflation? I am not saying what you offer is not good or that the public doesn't want it.

All I am saying is what is wrong with having legislation that allows the plans and the public to decide what it is those plans should include?

Mr. **Rosenfield**. Congressman, if you are thinking of an ideal world where things happen ideally, your plan might be effective, but this isn't an ideal world.

We have a long period of experience—not only in chiropractic. You have heard other witnesses say the same thing—of the doctor-oriented, doctor-controlled—and I mean medical doctor-oriented, medical doctor-controlled, medical doctor monopoly of the health care delivery system.

The result of saying we are not going to bar you from adding it is no different from what the present situation is.

In the present situation, without the requirement of mandates of one kind or the other, the medically-oriented profession has prevented these programs from going into effect because by and large they are the people that develop the plans, and the perfect example of that is the Federal employees' health benefits program.

Until recently chiropractic wasn't barred, but out of the large number of programs, only five or six included chiropractic in one form or the other.

Experience has shown that if there are some services that are important to include which are not within the purview of the customary medical monopoly, they will not be included in most cases.

Therefore, it is our judgment that unless you want an inferior form of health care service, which doesn't, in effect, give much opportunity for freedom of choice among them, you are going to find the lowest level excluding these nonmedical providers.

Mr. **Gephardt**. Thank you very much, Mr. Chairman.

Chairman **Jacobs**. Mr. Duncan?

Mr. **Duncan**. Thank you, Mr. Chairman.

I want to thank the panel. As usual, sometimes the last is the best we have for the day.

Since you have been covered, or your services have been covered under medicare, have you experienced any great problems in delivering your services?

Mr. **Nordstrom**. It depends upon the carrier. In some States there is a great deal of cooperation and understanding to move chiropractic into the program.

In other States it seems that this medical bias which a number of groups have talked about today has cropped up to the point where a number of chiropractors and their patients just don't frustrate themselves.

So it depends upon, again, the attitude of the people involved. To take off on Mr. Gephardt's question, again that is what we are concerned about; that the attitude among the majority of medical physicians and insurance carriers is antialternative health care.

Mr. **Duncan**. What are your views on Government regulations that you have to follow?

Mr. **Nordstrom**. Excuse me, Congressman?

Mr. **Duncan**. Government regulations, what are your thoughts on it? Government regulations that you must follow, the forms, other things required by the Government?

Mr. **Kenrick**. Yes, Congressman. It is a paper nightmare, frankly, for the chiropractor when we get into the medicare part of it.

However, our patients are being provided for. Not across the board. They still must—you see, they must pay for their own X-ray examinations.

They still must pay for their own out-of-pocket clinical examinations.

The thing that is provided for them is the actual chiropractic care. It is a system that we can live with. It is bare bones, and we are not asking you to—we are not asking you to give us a lot more than that. We can survive.

Our parties can survive with this. So I would say that basically we are happy with this. We certainly would not want to see it reduced because there wouldn't be much left.

Mr. **Duncan**. Has the cost of chiropractic care gone up since you have been covered, like everything else?

Mr. **Kenrick**. The cost of chiropractic care?

Mr. **Duncan**. Yes, sir.

Mr. **Kenrick**. In my office, no.

The cost of chiropractic care has increased. The cost of everything has increased. We try to keep pace with it as the cost of living increases. I haven't scaled up my fees just because medicare is picking up part of the bill.

Mr. **Nordstrom**. A recent study conducted for HEW indicated that we increased our fees at the same rate that medical physicians are, that we are just about 1 percent less.

Mr. **Duncan**. Thank you very much.

Thank you, Mr. Chairman.

Chairman JACOBS. I was a little confused about that. You say they increased as much as medical physicians, or 1 percent less?

Mr. NORDSTROM. Approximately 1 percent less per year.

Chairman JACOBS. You said just as much or less. I am confused by the disjunctive.

Mr. NORDSTROM. I think I just corrected myself in mid-sentence.

Chairman JACOBS. Mr. Gephardt?

Mr. GEPHARDT. I had just one other point to make, if anybody wants to respond.

That is, that I think often people confuse today's world and what has happened with services like those you perform and what I envision happening if we get to competition.

That is, you know, we have set groups that have offered health insurance plans today. Blue Cross-Blue Shield, the big insurance companies, some HMO's, et cetera.

My hope is if we get to a world of competition there will be lots of new and different groups offering health care plans to people, even more and different groups than offer it today to the Federal employees.

For instance, there would be nothing unlawful under H.R. 850 for a group of chiropractors, or a national group of chiropractors, to offer a plan that would include a broad range of services, including chiropractic.

I happen to believe that you are right when you say that there is a great following for your services.

That is obvious in the amount of people that have used it under medicare, the number of people that use it annually.

I just think you perhaps are more negative than you should be about your ability to participate in plans that would exist under a world of competition.

Mr. ROSENFIELD. Mr. Chairman, may I address myself to an observation and question from Congressman Duncan?

He asked if there were any problems. Congressman, when chiropractic was first introduced into medicare, there was a very serious problem in which we found chiropractors' judgment as to chiropractic treatment was being passed down by medical doctors which meant that the medical doctors said no in all cases.

This was abridged by the carriers very intelligently appointing chiropractic consultants to whom they referred cases as to which they had any questions.

On the whole, with the normal snafu that happens in any big program, that has worked very effectively.

We have recently learned of a major effort being organized by private companies working for carriers which are, in effect—they are called adjusting companies. They don't adjust as chiropractors, but they adjust claims.

These adjusting companies, some of whom represent 200 to 300 insurance companies, are cutting out all chiropractic consultants.

So that if that happens to be a basic pattern which goes on, we may be back to the original trouble, heaven forbid.

Chairman JACOBS. One question. Do you have figures on whether there has been an increase of medicare beneficiary participation in chiropractic services since the inclusion under the medicare coverage?

Mr. **Kenrick**. We know there has been, Congressman. As a matter of fact, the last figures I have, approximately 3 years ago we were caring for 4 percent of the general population.

In the last survey, we are now taking care of 7 percent of the general population. That is in just about 3 years, a big increase. We know medicare has increased because everything else has the number of beneficiaries we are taking care of but I don't have the precise figures at my fingertips.

Chairman **Jacobs**. Do we have figures to trace to find out if people perhaps wanted chiropractic services and were entitled to medicare benefits, but did not participate in chiropractic services because of the lack of coverage before?

Is that correct? There are no figures to show that?

Mr. **Kenrick**. I have no figures to show that.

Chairman **Jacobs**. I think that might be interesting.

Mr. **Nordstrom**. Yes, it would be.

Chairman **Jacobs**. OK, thank you very much.

Mr. **Kenrick**. Thank you very much.

Mr. **Rosenfield**. Thank you.

Chairman **Jacobs**. This concludes the hearings for today.

These hearings will resume at this place at 9 a.m. tomorrow morning, which will be October 1.

[Whereupon, at 2:30 p.m., the subcommittee was adjourned, to reconvene at 9 a.m., Thursday, October 1, 1981.]

PROPOSALS TO STIMULATE COMPETITION IN THE FINANCING AND DELIVERY OF HEALTH CARE

THURSDAY, OCTOBER 1, 1981

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

Chairman Jacobs. Will the first panel of witnesses please come forward.

The hearing will come to order.

The first witness for the Department of Health and Human Services is Dr. Robert Rubin, Assistant Secretary for Planning and Evaluation.

I might say for the benefit of potential witnesses, we have an unusually long list today and if each 5-minute witness only takes 2 extra minutes, it means the witnesses toward the end of the line will be an hour late, and so will the hearings. So we will enforce, with the exception of the administration's testimony, the 5-minute rule as though you were, say, before the Supreme Court, midsyllable, midsentence.

Also, that witness who is the most concise and briefest during the day will at the end of the day be awarded $1.

Dr. Rubin, you may proceed.

STATEMENT OF ROBERT J. RUBIN, M.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Rubin. Thank you very much. Perhaps in an effort to help our Department's budget, I would like to compete as well.

Mr. Chairman, the United States has long had the finest health care system in the world, and over the past two decades it has improved steadily. Not only have important medical advances enhanced the quality of care, we have made great strides in improving access to care for the poor and elderly.

Unfortunately, we cannot afford to rest on our laurels. As you know, health expenditures have grown from 6.2 percent of GNP in 1965 to 9.4 percent today. To put it another way, health expenditures have grown at an average rate of 12.3 percent from 1965 to 1979, a rate far in excess of the 9.2 percent annual growth in GNP. Although much of this increase reflects improving quality and access, some of the cost increases are due to inefficiency in our health care system.

As a physician, I feel confident that we can slow the rate of increase in health care costs without cutting into quality. For example, the Mayo Clinic—a multispecialty, fee-for-service, group practice that is renowned for its quality—hospitalizes patients at a rate 30 to 40 percent below the national average. Similar reductions in hospitalization have been achieved by well-established HMO's. Since hospital costs are about 40 percent of all medical costs, reduced hospitalization can mean lower health care costs and lower premiums.

The risk in not doing anything to address the health cost problem is great. Not only do spiraling costs mean higher inflation and taxes, they mean cuts in other Federal programs that otherwise would not have to be made. Finally, the uncontrolled rise in health care costs prevents us from meeting the needs of those Americans who are underserved but who now fall in the gaps of the existing array of public programs.

The position of this administration on how to improve the efficiency of the health care system is straightforward: We must rejuvenate the market for health care so that insurers and health care providers compete aggressively for the dollars of consumers and seek out ways to cut the cost of providing necessary medical services.

This approach to the health cost issue—an approach often labeled "procompetition"—has received increasing attention in the academic literature on health policy and more recently here in Washington. Indeed, members of the Ways and Means Committee have contributed immeasurably to competition's becoming a credible health policy option.

Nevertheless, the single most important factor behind the growing interest in competition is the evident failure of regulation. We have been through a decade of regulatory experimentation with few promising results. During the last administration, moreover, Congress took a long and careful look at where the regulatory approach was headed—hospital cost containment—and found that approach wanting.

That is not to say that the road to a more competitive marketplace will be smooth. On the contrary, as chairman of the HHS task force on competition, I know very well that the issues are difficult. As a result, considerable analytical work must still be done before the administration is prepared to offer its own proposals or to comment in any definitive way on the bills now pending before Congress.

Let me conclude my introductory remarks by saying that the market does not need a comprehensive, procompetitive reform bill before it begins to work. There are in fact encouraging signs that employers, unions, insurers, and health care providers are voluntarily beginning to seek out ways to improve the efficiency of the health care system. Health care coalitions are being formed, HMO's are growing, and providers are seeking ways to reorganize themselves more efficiently. These are all promising developments, and we will do our best to encourage them, notwithstanding what happens in the coming months as we debate competition legislation.

Mr. Chairman, with your permission I would like to submit my formal testimony for the record in an effort to save the committee time.

[The prepared statement follows:]

STATEMENT OF ROBERT J. RUBIN, M.D., ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

INTRODUCTION

I am pleased to be here today on behalf of the Department of Health and Human Services. Thank you for inviting me to testify. Today I would like to discuss six general areas:

1. Key trends in the health care sector today;
2. Alternate approaches to controlling health care costs;
3. The status of our work on a "competition" bill;
4. The cost management efforts already underway by private business;
5. Ways to reform the public sector health programs; and
6. The impact of the "competition" approach on providers.

CURRENT STATUS OF THE HEALTH CARE SECTOR IN THE UNITED STATES

It is well known that the health sector is a large and growing part of our economy. It is the nation's third largest industry and employs about six percent of the work force. The following statistics profile the health sector and how it has changed since the 1960's:

Health expenditures rose from 6.2 percent of GNP in 1965 to 9.4 percent today.

Health expenditures grew at an average annual rate of 12.3 percent from 1965 to 1979—a rate far in excess of the 9.2 percent annual growth in GNP.

Although the estimates vary, approximately 20.5 million people have no insurance coverage. 28 million participate in Medicare; 23 million are eligible for Medicaid; 141.3 million have group insurance; 19.9 million have individual insurance and 5.4 million are covered by other governmental programs. (There is some overlap in counting, especially between Medicare and private plans.)

Medicare payments have increased from .76 percent of GNP in 1970 to 14 [1.4] percent in 1980.

These expenditures have brought the U.S. the finest health care system in the world. We have redressed many inequities in access to health care by the poor, minority populations, rural populations and the elderly. We have supported medical research and have accumulated a capital stock of medical equipment and health care facilities that have brought dramatic improvements in medical technology and the capabilities of doctors and hospitals to treat the sick. Since the enactment of Medicare and Medicaid in 1965, increases in utilization have been particularly notable among low-income and elderly persons.

The percentage of poor persons with no physician visits during a two year period has declined from 28.2 percent in 1964 to 14.3 percent in 1978.

The number of physician visits per year made by poor persons has increased from 3.9 in 1964 to 5.6 in 1978.

In 1964, 18.7 percent of the nonpoor elderly had no physician visits in the previous two years. By 1978, that had declined to 12.8 percent.

While there are a number of reasons health care expenditures have risen, two in particular have had a major impact: General inflation in the economy and the rising rates of utilization. Over 50 percent of increase in health costs in recent years have been caused by general inflation in the economy. This inflation has a tremendous effect on the cost of entitlement programs in the Federal Budget. For example, in 1981, the adjustments required just for the cost-of-living and inflation resulted in budget increases of: $5 billion in Medicare; $14.9 billion in Old Age, Survivors and Disability Insurance; and $560 million in Supplemental Security Income; and the total increases required were $20.5 billion.

Federal outlays for current law benefits under Medicare and Medicaid in fiscal year 1981 will exceed $57 billion. At current growth rates, this spending will more than triple by 1990. As mentioned earlier, Medicare consumes an ever growing share of the country's GNP.

In some regards, we are now paying the price for years of important accomplishments. If given our choice, I doubt that many of us would trade the health system we have now for the lower costs we used to pay. However, the rate of growth of health care costs is too high and it represents too great a burden for both the Government and the private sector.

However, I want to point out that I do not subscribe to a "bad guy theory" of why costs are rising. Costs are rising and are outside the control of normal market forces because the current insurance system (public and private) is inherently inflationary, filled with bad incentives for all parties and in desperate need of reform. None of the parties themselves are "bad guys" or are to "blame," but all the parties are operating in a system that encourages costly and inflationary behavior.

We can no longer afford the current rate of inflation in the health sector. As you are aware, the President's budget and tax policies are designed to revitalize the nation's economy and put the brakes on runaway inflation. These policies will have a major effect on the health sector, but they alone cannot reverse the trends of recent years.

DIFFERENT APPROACHES TO THE COST PROBLEM

Previous administrations sought extensive regulatory controls on providers as a way to try to slow health care increases. The regulatory strategy has not worked, primarily because it addresses symptoms rather than causes of the problem.

The tendency to reach for regulatory controls on providers is understandable. There are a lot more patients than there are doctors and hospitals. And from a political perspective, these controls on providers appear to allow consumers to escape the effects of cost control measures. Indeed, regulatory controls on providers often tend to attract much positive press and create the feeling that government is doing something about budget outlays.

While the government is stressing cost control through regulations, patients are not rewarded for seeking less expensive or only essential care, and thus frequently end up seeking the most expensive care. Providers have no incentives to be efficient or develop innovative, cost-effective, or more appropriate patterns of care.

A new approach to rising health costs has been simmering for the past two years and is supported by this Administration. The approach has been referred to as "pro-competition." Its major premise is that consumer choice and market forces, rather than regulation, should be relied on to control health cost inflation.

STATUS OF HHS WORK

During the past six months the Department has been involved in an intensive study and analysis of the problems in the health care sector and the promise that a "competitive approach" holds for addressing these problems. We have established a task force within HHS (see member list in Appendix A), and we regularly confer with representatives from the private sector and other state and federal government agencies who are also studying the problem. We are now in the process of formulating the specific provisions of a legislative proposal, and I would like to outline our major areas of study at this time. Our efforts focus on six topics, including:

1. The incentives in the health financing system which lead to excess costs.
2. The desirability of having consumers and public program beneficiaries choose their health care coverage from a "multiple choice" listing of competing plans.
3. The cost containment potential of alternative delivery systems, e.g., HMOs, and ways to encourage competition among health care providers.
4. The kinds of plan qualification or minimum benefits (if any) that should be required.
5. Medicare/Medicaid reform, including the possible use of a voucher system under which beneficiaries could elect to "cash-out" their benefits and enroll in private insurance plans or alternative delivery systems.
6. A variety of issues associated with "the competitive approach" including, for example, the effects of the competitive approach on teaching and public hospitals, the implications for access to care by the poor and elderly, the future capital needs of hospitals, and the effect of the future increased supply of physicians on the medical marketplace.

At this time, we have not developed specific recommendations in many of these areas. Rather, as I mentioned previously, we are in a period of intensive study and analysis.

I should point out here that the term "competition" means many different things to different individuals and constituency groups. The basic theory is simple. Incorporating it into a specific legislative proposal is not so simple, as it involves myriad questions that go to the core of our country's health care financing and delivery systems, both for public entitlement programs and private health insurance.

One approach to competition is consumer choice. The consumer choice idea rests on a simple premise: If consumers had several insurance options, each with different levels and types of coverage, different cost sharing arrangements and different financial consequences, they would make cost-conscious choices about their use of health services and the cost of what they use. Insurance companies and alternative delivery systems would then be induced to offer health plans that provide a given level of benefits at the lowest cost in order to get business. This is hardly the way hospitals have competed in the past.

Competition over premiums could be expected to produce some plans with higher patient cost sharing and a concomitant increase in consumer interest in shopping for low cost, efficient providers. It should also encourage consumers to question the necessity of some services, particularly those delivered in high cost settings.

In addition, competition over premiums should encourage insurers (and others) to negotiate payments to physicans and hospitals. This could lead to reform in retrospective reimbursement to hospitals. The current retrospective cost reimbursement system is inflationary; it pays inefficient hospitals as much as it pays efficient ones; it requires a hugh bureaucracy to administer and induces providers to waste a lot of time "gaming" the system rather than trying to operate more efficiently.

Finally, competition among health plans provides a much needed alternative cost containment strategy to government regulations. As mentioned earlier, the history of federal and state regulation of health care costs has been one of failure and frustration.

HEALTH COST MANAGEMENT IN THE PRIVATE SECTOR

While there are problems in the health sector, there is some evidence that the private health market is *beginning* to work. For the general population, utilization of hospitals is stabilizing: the increase in admissions per 1,000 people is slowing and the typical length of stay decreasing. More importantly, alternative and more cost-effective delivery systems are developing.

Growth of prepaid plans is strong, with a declining number of plans due to consolidation but gains in the total number of enrollees and the market share of the prepaid plans. The major insurance companies, such as Prudential and the Insurance Company of North America, now experiment with prepaid care plans as a new line of business. Moreover, support from private employers now goes beyond mere compliance with the federal HMO Act of 1973.

In addition to prepaid plans, a variety of other ambulatory care facilities and services are developing and many are financed through private investment. Ambulatory surgery centers, home health agencies, freestanding emergency/trauma centers and various diagnostic and treatment centers are good examples. In essence we are witnessing the birth of a "para hospital" sector with much long run potential for cost savings, more appropriate levels of care and care that is more attractive to and convenient for consumers.

The long run strategic problem is to make sure that physicians and patients have incentives to use these new facilities and services instead of more expensive ones. This requires modification of current insurance options for patients and reimbursement provisions for providers.

The private business community is developing substantially improved knowledge about its health care use and costs. It is more committed than ever to work with health providers to reduce costs and improve the quality and appropriateness of care. Most importantly, business efforts often occur at the local level where solutions to health care cost and utilization are most likely to be found.

A very recent and important innovation, "business-health coalitions", offers much hope for business to shape the health care system. Over 50 such coalitions currently exist and there are success stories already. Only a few years ago there were just a handfull of coalitions.

In addition to supporting and developing prepaid care and coalitions on health costs, business is actively developing better management techniques for health benefit costs.

Employer efforts in health cost management are varied but can be categorized into four categories: (1) changing economic incentives for employees and re-designing benefit packages (a small but growing number of firms are offering multiple choice or "cafeteria" benefit plans); (2) developing information systems to better monitor utilization and costs; (3) enhancing the knowledge and role of business employees who serve as hospital trustees; (4) offering health promotion or "wellness" programs to employees.

This just highlights some of the major private sector initiatives. One of the most important characteristics of the private sector is its great diversity. I would not presume to tell you that there is one right solution to the problem of rising private health care costs. Rather, there are a host of unexplored possibilities out there that we want to encourage private industry to explore. While the steps taken by the private sector are encouraging, they are not enough. We want our work to hasten constructive change by business. We will support private sector cost containment efforts and will take care not to restrain U.S. employers and health care providers from solving their cost problems in innovative ways. We will undoubtedly learn from them.

WAYS TO REFORM PUBLIC SECTOR HEALTH PROGRAMS

The private sector can change the health care system in many ways, but the public sector must also change if we are to expect any significant reduction in costs. The government is the principal bill payer in the health care sector, and its actions affect total health care costs. One question that our work has focused on is, "What can the government do to promote cost conscious behavior in the public sector?"

MEDICARE PROBLEMS AND SOME POSSIBLE CHANGES

Medicare currently provides hospital and medical insurance coverage to approximately 28 million people who are over the age of 65, permanently disabled, or suffering from end stage renal disease. Medicare program expenditures constitute approximately 14 percent of national health expenditures. While the government role in financing the health care of the elderly is impressive, Medicare and Medicaid pay less than 60 percent of the health expenses of the elderly. Over half of the beneficiaries purchase insurance to fill the gap between Medicare and their actual expenses.

We have a particular concern with the rising cost of Medicare. Part of the increased cost is the result of an aging population. In 1967, 17.8 percent of Medicare enrollees were over 80; by 1983, 22.3 percent will have reached 80.

Advances in the detection and treatment of disease have expanded our life expectancy and with that expansion has come an aged population more likely to require health services. The over-65 population is currently growing at roughly three times the rate of the general population. The hospital admission rate for the over-65 group is three times that of the under-65 population. Each of their hospital stays is far more expensive than the average admission because the patients are older and sicker and require more intensive treatment. We anticipate even greater progress in biomedical research and prevention in the future. Thus, if we are going to be able to afford to care for the elderly, we must take serious steps now to reduce the rate of increase of expenditures in the health sector. Indeed, the magnitude of the Medicare cost problem will only worsen as the "baby boom" population of the 1940s and 1950s become Medicare beneficiaries in the years after 2000.

I would like to discuss one possible change in Medicare that could improve the program.

VOUCHERS FOR MEDICARE BENEFICIARIES

One approach may be to give Medicare beneficiaries vouchers with which to purchase private health insurance. Private health plans have greater flexibility than the government to adjust health insurance benefits to encourage cost conscious behavior. Further, Medicare law mandates the benefits that the beneficiary population will receive and leaves no room for indivisual choice. Changes in the private sector allow for freedom of choice—if you don't like the plan you can "vote with your feet."

CONCLUSION

Let me conclude by saying that the alternative to reform is *not* the status quo. The current system is inherently inflationary and based on the wrong fundamental incentives for virtually every party—patients, hospitals, doctors, insurers, employers and government regulators. One alternative is more regulation—arbitrary caps on every health budget item, more paperwork, less innovation and less patient satisfaction. That course ultimately leads to utility regulation with government rationing and rate setting.

Congress twice defeated hospital cost containment bills from the previous Administration and sent a clear message for reform in health care without a regulatory approach. The President's approach to the economy emphasizes less federal government regulation, reduced federal government spending, more power and responsibility for the states, and improved incentives for the private sector. The pro-competitive philosophy is consistent with the mood of the people as well as the country's fiscal pressures. The various proposals now pending in Congress, and the bill now being prepared by this Administration, offer a new way to alleviate the health care cost problem.

The success of a competitive strategy rests on our ability to influence the behavior of doctors, hospitals, consumers and insurers through marketplace incentives and penalties rather than government regulation. It is an idea whose time has come.

Dr. **Rubin**. I would like to call your attention to the fact that on page 2 of our prepared testimony there is a rather significant typographical mistake. That is that medicare payments have increased from 0.76 percent of GNP in 1970 to 1.4 percent rather than the 14 percent that was listed in the testimony.

Chairman **Jacobs**. Things never are as bad as they seem.

Dr. **Rubin**. Thank you.

Chairman **Jacobs**. Thank you for your presentation, Dr. Rubin. Do I infer then, not only infer, do I hear correctly that the administration does not care to comment on proposals for tax changes with Federal income tax with respect to deductions for health care or health care insurance?

Dr. **Rubin**. Not at this time, that is correct.

Chairman **Jacobs**. I suppose the logical question is, if not now, when?

Dr. **Rubin**. Well, the Secretary has made very clear that it is our intention to have a bill before the Congress before the end of the year. The Secretary actually uses the words "by the end of the fall."

As you know, the winter begins on December 21. That is close enough to the end of the year for government work, I guess.

Chairman **Jacobs**. Right.

Then actually, I suppose the administration anticipates congressional disposition during the second session of this Congress.

Dr. **Rubin**. That is correct.

Chairman **Jacobs**. Would you care to make any comments at all about the proposed voucher system under medicare?

Dr. **Rubin**. We are currently looking at a voucher system for medicare, Mr. Chairman. We think there are several problems with the voucher system that we are looking at.

I believe yesterday the Congressional Budget Office testified, and they also raised problems with the voucher system. We are not prepared to discuss a voucher system that we would put into place if that would be what we were to propose.

It is our understanding that other members of the committee have a voucher system proposal. We have taken a look at it. We have provided some comments in sort of a technical assistance category.

Chairman **Jacobs**. Do you anticipate, personally, one of the difficulties with the voucher system might be that if a very elderly person discovered that he or she made the wrong choice, to wit, was not covered for a substantial hospital bill, that the only way to correct that was perhaps next time he lived?

That might be it, literally either a fatal or final error. We had testimony yesterday that a person could always go back and correct the error. Do you subscribe at least theoretically to the notion that there is a little bit of closing the barn door after the horse gets out in that logic.

Dr. **Rubin**. No, sir, Mr. Chairman. I believe if we had a voucher system, that any voucher system ought to contain the provision of the catastrophic component so that the kind of errors in judgment that you talked about would be unable to occur. That is to say, there would be a limit on a person's out-of-pocket expenses, and after that amount the catastrophic component, which is provided by the private sector, would come into play to prevent any further financial damage.

Chairman JACOBS. I take it you would agree that one person's catastrophe could be another person's incident so far as capacity to pay is concerned.

Dr. RUBIN. That is certainly true, people have different sensitivities toward out-of-pocket medical expenses. It would be our hope we could make a catastrophic limit should we propose a voucher system, something that would be a reasonable floor below which people couldn't fall. Clearly, as well, we currently have a medicaid system that is in essence the payer of last resort for people that have extraordinary medical expenses and we would propose keeping that system.

Chairman JACOBS. Is Federal income tax modification on the table in the deliberations of the administration, or is it off limits in your proposals at this time?

Dr. RUBIN. Roughly 3 weeks ago, Mr. Speakes, presumably speaking for the President, said it was not the intention of this administration to tax people's health insurance benefits. To the best of my knowledge, that position is still extant.

Chairman JACOBS. One never knows.

Dr. Rubin, we are very grateful to you for your testimony, which is part of the record both formally and in the extemporaneous portion. And we look forward to the administration's proposal and I guess that is it.

Thank you.

Dr. RUBIN. Thank you very much.

Chairman JACOBS. Will the next panel please come forward.

So as to avoid repetition, I wish each witness as he delivers his testimony to identify himself and his organization, and again remember the 5-minute rule. I repeat, the incentive reward for the person who falls furthest below the 5-minute rule will be $1.

To assist in following the 5-minute rule, by the way, we have an egg timer. If you hear a ding, that means the 5 minutes are up.

Why don't we just set a rule for today that we will proceed from your left to right.

STATEMENTS OF DON A. EICHELBERGER, CLU, CHAIRMAN, COMMITTEE ON FEDERAL LAW AND LEGISLATION, NATIONAL ASSOCIATION OF LIFE UNDERWRITERS, AND JOHN F. GRAFF, CLU, RHU, CHAIRMAN, SUBCOMMITTEE ON HEALTH

Mr. EICHELBERGER. Mr. Chairman, members of the committee, my name is Don Eichelberger. I am a practicing life insurance agent from Waterloo. Seated next to me is John F. Graff, a life insurance agent from Chicago, Ill. We are appearing here today as representatives of the National Association of Life Underwriters.

NALU appreciates the opportunity to discuss the pros and cons of legislative proposals with the purported aim of reducing the cost of health care by fostering competition among providers.

The National Association of Life Underwriters is a federation of approximately 1,000 State and local associations which in turn have a combined individual membership of over 131,000 life and health insurance agents, general agents, and managers doing business in virtually every community in the United States. The individual member of the local associations are called life underwriters who, as individual business people, have been in the health insurance business from its very inception.

NALU commends the Subcommittee on Health for holding these hearings to develop proposals to stimulate competition in the financing and delivery of health care and to involve the individual more directly in the choice of his own health care.

I would ask Mr. Graff to proceed.

Mr. **GRAFF**. Mr. Chairman, we request that our prepared statement be inserted for the official record. In the essence of time, I believe we can summarize the major points of our testimony into five specific areas.

First, we feel quite strongly that the procompetition proposals pose a threat to the regulation of the insurance business by the States. The McCarran-Ferguson Act specifically reserves to the States the right to regulate insurance. We believe this State regulation has been very responsive. In addition, most of these bills would also create some form of Federal component to regulate the mandatory requirements. We feel that that stronger State regulation which is closer to the problem is the answer to the problem that H.R. 850, 5139, and 5433 are attempting to solve through more regulation at the Federal level.

Second, requiring an employer to offer employees a choice of at least three different health benefit plans, limits the employer's ability to purchase the best coverage available at the lowest cost. In fact, many group insurance plans offer a discount, a $1 discount if the number of employees enrolled is in excess of a hundred. An employer with 250 employees that must offer three different plans, perhaps a high option, a low option and an HMO could lose a discount from the existing insurance carrier because none of the plans would have 100 or more employees enrolled. We think this also impinges on the typical employer-employee relationship that is prevalent throughout the country.

A third point, a limit on the maximum tax deductible employer contribution toward a health benefit plan would not necessarily stimulate the employer to create better health care plans. If we had a fixed dollar limit, there is always an excellent possibility that an employer may modify his group insurance plan, insert new deductibles, new copayments to bring the cost of that plan either equal to or below a fixed dollar amount that might be mandated. This in essence could reduce the benefits payable under that plan, also create a very serious problem with collective bargaining plans currently in place throughout the country.

Our fourth point, to require an employer to make equal contributions to each type of plan may result in a lower quality of health care. This is similar to point No. 3, where the benefits could be diluted and would not work in the best interests of the goals that the proposed plans are attempting to accomplish.

Finally, we do support the inclusion of a catastrophic component. If a catastrophic insurance component is mandated, we are in favor of a $3,500 deductible indexed to keep pace with inflation.

Finally, we think really in essence all of these pieces of legislation actually deal with theory, none of which has been proved, and we would restate again our position that we think State regulation is the answer, State regulation is responsive, it has worked well, and we are not in favor of any type of Federal legislation that would impose Federal mandates and impinge on the State regulation of the insurance business.

[The prepared statement follows:]

STATEMENT OF DON A. EICHELBERGER, CLU, CHAIRMAN, COMMITTEE ON FEDERAL LAW AND LEGISLATION, AND JOHN F. GRAFF, CLU, RHU, CHAIRMAN, SUBCOMMITTEE ON HEALTH ON BEHALF OF THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

SUMMARY

Pro-competition proposals pose a threat to the regulation of the business of insurance by the states.

To require an employer to offer employees a choice of at least three different health benefit plans severely limits the employer's ability to purchase the best coverage available for his employees at the best price.

A limit on the maximum tax deductible employer contribution toward a health benefit plan would not stimulate the employer to create better employee health care plans.

To require an employer to make equal contributions to each plan may result in a lower quality of health care.

NALU supports the inclusion of a catastrophic expense protection.

STATEMENT

The National Association of Life Underwriters (NALU) appreciates the opportunity to discuss the pros and cons of legislative proposals with the purported aim of reducing the cost of health care by fostering competition among providers.

The National Association of Life Underwriters is a federation of approximately 1,000 state and local associations which in turn have a combined individual membership of over 131,000 life and health insurance agents, general agents, and managers doing business in virtually every community in the United States. The individual members of the local associations are called life underwriters, who, as individual business people, have been in the health insurance business from its very inception.

NALU commends the Subcommittee on Health for holding these hearings to develop proposals to stimulate competition in the financing and delivery of health care and to involve the individual more directly in the choice of his own health care.

We strongly advocate individual responsibility in this area. For example, NALU has produced an audio-visual presentation called "Your Risk and Mine" (cassette tape and slides) on the subject of an individual's responsibility for his/her own health care. A copy of the script is attached to this testimony.

The audio-visual describes the problem of the high cost of health care; what some of the solutions may be and how the individual can favorably affect the system. Too often, we believe, people are insulated from the actual cost of their own health care because they are not individually paying the bills.

We have encouraged our 1,000 local and state associations to show this audio-visual to local church and social groups, Chambers of Commerce, labor organizations, civic associations and any other groups where people who might benefit by seeing it congregate.

Several proposals have been introduced in the 97th Congress whose purpose is to stimulate competition in the financing and delivery of health care. Collectively, these bills are grouped under a banner known as Pro-Competition legislation. "Procompetitive" legislation introduced to date includes: H.R. 850, National Health Reform Act of 1981 (Rep. Gephardt); S. 433, Health Incentives Reform Act of 1981 (Senator Durenberger); and S. 139, Comprehensive Health Care Reform Act (Senator Hatch). In addition, the Reagan Administration is presently preparing a "procompetitive" proposal and has expressed its intention to submit legislation on point during this Congress.

These various proposals to stimulate competition among health care providers emanate from the unprecedented rise in health care costs experienced over the past decade. Ideally, pro-competition would lead providers of health care to compete for patients based on the quality of care and management efficiency. Those groups offering the best quality and management would, in theory, be rewarded with more business.

While NALU subscribes to this theoretical end, the legislative proposals thus far introduced use the employee/employer relationship as a means of attempting a solution to the cost escalation in health care. It is our contention that emphasis on the employer/employee relationship will have little effect upon competition among providers of health care. That being the case, there is no indication that it will solve the problem. We believe further that the proposals as they now stand are not in the best interest of individuals.

We are not convinced that because individuals have a pecuniary interest in paying for health care, that they will exert pressure on providers or that such pressure will have a significant effect. A revealing statistic gathered by HHS indicates that Medicare pays about 38 percent of the Medicare populations' medical costs. That leaves a sizable gap in costs to be made-up out-of-pocket or through Medicare supplemental insurance. Yet, this group has been unable to have a marked effect on health care costs as far as we know.

Before examining some of the details of the various proposals, we wish to emphasize that NALU favors state regulation of insurance. NALU believes that decentralized regulation at the state level is more responsive and adaptable to the needs of those people regulation seeks to protect. NALU believes state regulation will best serve the long-range interests of the insurance industry and the insuring public.

This posture will be evident later in our testimony, but is mentioned here because of our concern about people who are underinsured, uninsured altogether or have gaps in their coverage. NALU recommends that the function of filling voids in insurance coverage be left to the states to undertake.

To require an employer to offer employees a choice of at least three different health benefit plans severely limits the employer's ability to purchase the best coverage available for his employees at the best price

The reality of the marketplace dictates that if an employer is able to insure his entire work force with one policy, he will generally be in a better bargaining position in the insurance market than if he must provide a number of different plans. In other words, he has at hand an economy of scale when he has only one plan to purchase because a greater number will be included in that plan, thus reducing its cost. He loses this economy when he must provide more than one plan.

For example, many group insurance contracts offer size discounts. If an employer has 117 employees enrolled in a plan, and a discount is offered for plans with 100 or more participants, this discount will be lost if the employer is forced to carry alternative plans with, perhaps, one plan having forty employees in it, and the other 77.

Furthermore, the cost to the employer of establishing and administering three plans as opposed to one may discourage employers from offering any health insurance plan at all to their employees, thus defeating the avowed purpose of the bill.

A limit on the maximum tax deductible employer contribution toward a health benefit plan would not stimulate the employer to create better employee health care plans

We believe that a limit on the tax deductible contribution would reduce an employer's incentive to design a health care program that would cost more than the employer could deduct. But, such a maximum limit may well encourage employers to decrease existing benefits for employees now receiving contributions greater than the limit. Furthermore, a national limit would not take into account geographical differences in health costs.

Health costs vary widely throughout the country. While this set amount may be equitable in some areas, it may work a hardship on some employers in areas where the costs of medical care are considerably higher. Significant differences in health costs can be experienced even within a community.

To require an employer to make equal contributions to each plan may result in a lower quality of health care

We find the "equal contribution requirement" to be somewhat troublesome. Under this provision, any employer offering more than one coverage option must contribute equally to each option regardless of which option the employee chooses. If the employer's contribution exceeds the actual cost of the particular option selected by the employee, then the employee is entitled to receive a rebate equal to the difference and, at his option, may receive this rebate in cash.

We see this proposal as a dangerous means by which an employee could be induced to choose the health plan of the poorest quality in order to receive a cash rebate. This would have the effect of decreasing rather than increasing the quality of health care for individuals.

NALU supports the inclusion of a catastrophic expense protection

S. 433 mandates the inclusion of a catastrophic expense protection. NALU supports catastrophic health insurance coverage, although, we are uneasy in supporting it as part of a federal legislative proposal. In any event, we are in favor of the $3,500 deductible limit as set forth in S. 433. However, we do suggest that it be indexed to keep pace with inflation so as to prevent the deductible amount from being rendered meaningless by rising inflation.

"Pro-competition" proposals pose a threat to the regulation of the business of insurance by the States

S. 433 provides that the Secretary of Health and Human Services establish certain standards to guarantee that premium rates on conversion of group policies be "reasonable." Although the bill provides that the determination of the premium rates shall reside with the appropriate state agency, the establishment of standards which would govern that determination would be an unwarranted and we think objectionable intrusion into the power of states to regulate the business of insurance.

H.R. 850 provides that the Secretary of Health and Human Services would essentially assume the role of regulator of group insurance plans. All group plans would report to the Secretary once each year the number of subscribing members, the amount of premium charged, changes in qualified plans such as increased deductibles or lower benefits, and financial statements as required. Furthermore, the bill creates a new federal agency, the Health Benefits Assurance Corporation, to review and certify the financial soundness of qualified plans. This legislation also requires brochures to be printed and submitted to the Health and Human Services Secretary containing complete details concerning the plan.

The McCarran-Ferguson Act, 15 U.S.C. 1011-15, establishes federal policy with respect to state regulation of the business of insurance. It is ironic that given the resurgence of federalism and states rights, that H.R. 850 would at this time undertake to nullify the authority of the states to regulate insurance. H.R. 850 contains an amendment to the McCarran-Ferguson Act specifically making the Federal Antitrust Acts "applicable to policies of insurance or re-insurance offered to qualified plans under (H.R. 850), and to persons providing such policies, regardless of whether such business or persons are regulated by state law."

This represents a considerable abrogation of state authority to regulate the business of insurance. NALU fully favors and supports the regulation of insurance by the several states and opposes any amendment to the McCarran-Ferguson Act that would undercut this authority.

The bills contain further abrogation of state prerogatives in provisions requiring the employer to continue coverage under group health benefit plans for terminated employees. Group health insurance is the subject of legislation and regulation throughout the states and the provisions concerning continuation after the group coverage terminates are covered by these laws and regulations. The states have also acted in other areas concerning health care. Some examples are prospective budget review; health planning; assigned risk pools; and regulation of HMOs.

Given the responsiveness of the states in attempting to reduce rising health care costs and the efforts afoot to allow the states to regulate those areas most properly within their purview, NALU feels that any federal regulation is ill-advised.

CONCLUSION

We wish to emphasize that the National Association of Life Underwriters shares the deep concern evidenced by this committee for the rise in health care costs and the critical need to control them.

It is one of the basic tenets of our Association that, given the challenge, the competition in the marketplace can adequately respond to the needs of the consumer. We believe that the proposals we have examined would not be "pro-competition" but rather, would create a regulatory network that would result in additional administrative costs which would far outweigh any savings that might purportedly be achieved.

YOUR RISK—AND MINE (REVISED "RISK WORTH SHARING")

Video	*Audio*
1. Title Slide	1. Music Up
2. Man in Hospital	2. Medical care . . . a vital, expected and expensive commodity in today's world—
3. World map w/Inflation burnt through	3. And, like most things in our inflation-riddled economy,
4. Doctor treating patient	4. The life-prolonging miracle of modern medicine is becoming increasingly expensive.
5. Graph	5. In 1976, we Americans spent over $140 billion, or $522 per person, on health care.
6. Graph	6. But by 1978, the total tab had risen to more than $192 billion, or $863 per individual.
7. Crowd shot	7. Yet most of us are shielded from the continually-increasing cost of health care
8. Hospital bill	8. Because we think someone else—insurance or government—is paying our medical bills.
9. Man tossing bill aside	9. As a result, we tend to forget the small economies that can have such a significant effect on that total,
10. Man looking at bill	10. And then complain when the cost of third-party payment—
11. Copy: Premiums, Taxes	11. Insurance premiums or taxes for such programs as Medicare or Medicaid—
12. Newspaper Head: Health Care Cost Rises; Medicare Budget Increased	12. Rise to reflect the higher costs paid by private insurers and government. (Pause, Music Down)
13. People walking	13. There is much that we as individuals can do to control spiralling health care costs,
14. Individuals, w/Understand burnt through	14. But first, it's important to understand why individual actions are so important,
15. Health Care puzzle	15. And how they affect the big picture. (Pause)
16. Copy: Risk-Sharing	16. The foundation of our private and government insurance systems is the principle of risk-sharing.
17. 4-way split: people	17. This means that many individuals pool a small portion of their resources to create a large fund
18. Same as #4, w/arrow pointing to dollar sign	18. from which to pay the expenses of those pool members who become sick or injured.
19. Woman in hospital bed	19. Thus, in the short run, a few benefit financially from the collective efforts of many . . .
20. Family w/Security burnt through	20. While each pool member is secure in knowing that his or her medical bills will be met should ill health occur.
21. Crowd w/Protection burnt through	21. And in the long run, all pool members win in terms of both claims paid and on-going security.
22. Copy: Individual Contributions = Premiums	22. The individual contributions are the premiums paid for private health insurance
23. Copy: Individual Contributions = Premiums and/or Taxes	23. And/or the taxes paid for government-sponsored health care programs.

24. Man writing check	24. Viewed this way, it becomes obvious that it isn't someone else who is paying the tab—it's us.
25. Copy: Risk-Sharing	25. It is, indeed, a risk-sharing, not a risk-shifting, system. (Pause)
26. Magnifying glass w/Control to one side	26. Now, let's examine how we can control the size of claims paid,
27. Pile of money, w/Control burnt through	27. And thus control the amount we each need to contribute to create a fund large enough to meet those claims.
28. Copy: Providers, Government, Insurance, Individuals	28. To begin, consider the component parts of the system.
29. 4-way split: Doctor, nurse, clinic, hospital	29. Health care in this country involves providers—doctors, nurses, hospitals, clinics, etc.,
30. Liberty bell/ins. co. logos	30. Government and the insurance industry as primary financers of the cost of medical care,
31. Man/Woman	31. And individuals, as consumers and as those ultimately responsible for providing the money to pay health care bills.
32. 3-way split: worker, executive, health pro	32. This partnership works most efficiently when each member cooperates with the others' needs.
33. Board of Directors meeting w/Organizations ARE People burnt through	33. And, because individuals, in the final analysis, are responsible for industry and government policies and programs,
34. Man at blackboard	34. It is individual input and concern that actually determines the effectiveness of the entire system.
35. Man handing another man a check	35. In addition, it is the individual who benefits from this careful control.
36. Copy: What Can We Do?	36. But, just what is it that each of us can do?
37. Hand reaching for bill	37. In general, each individual can demand and carefully review itemized hospital bills;
38. Woman at phone	38. Each can use, when appropriate, alternative, less expensive forms of care
30. 3-way split: clinic, mother, appointment	39. Such as clinics, nurse practitioners, or scheduled doctors' appointments
40. Hospital emergency room	40. Instead of relying totally on the more costly hospital emergency room.
41. Kids going to YMCA	41. We can also make or renew a commitment to taking good care of ourselves,
42. 2-way split: Kid w/apple racquetball	42. For good diet, proper exercise, sufficient rest and regular check-ups
43. Hospital	43. Will not only make us feel better, but will also lower our medical bills.
44. Town meeting	44. More specifically, as persons involved and as persons affected, we should encourage each other, industry and government in cost-containment efforts.
45. Person checking bills	45. We can urge the insurance industry to continue its careful review of bills,
46. Company logos w/coinsurance, initial deductible provisions burnt through	46. And its cost-efficient co-insurance and initial deductible provisions.
47. Hospital bill, w/ins., individual portions shown	47. These provisions not only encourage us, as consumers, to keep our bills as low as possible,

48. Clerk in accounting office	48. But also, they minimize the administrative cost of paying claims by reducing a potentially huge number of small claims.
49. Car on scenic highway	49. As with car insurance, the co-insurance and deductible provisions keep the total premium far lower than would be possible without them.
50. Doctor's waiting room	50. We can also encourage the private insurance industry to continue its development of such product innovations as coverage of regular check-ups,
51. Jogger	51. Policy discounts for those who take good care of themselves.
52. One person consulting doctor	52. Or payment for second opinions before deciding on elective surgery. (Pause)
53. Man writing to legislator	53. Government, through contact with legislators, should be encouraged
54. Capitol w/Programs, Tax Incentives, burnt through	54. To limit its role to aiding those who can't provide for themselves, designing tax and other incentives for wise planning,
55. American flags, w/"Guaranteed Access" burnt through	55. And to establishing motivation and/or programs to make sure all Americans have access to quality, affordable health care. (Pause)
56. Individual, highlighted	56. Individual effort within the health care provider sector is important, too.
57. Meeting w/Planning Boards burnt through	57. Community representatives serve on hospital and clinic planning boards,
58. US map w/HSA burnt through	58. And on Health Systems Agencies—HSAs—which oversee the geograhic and population-based distribution of equipment and facilities.
59. Doctors' meeting	59. Individuals can support practitioners who form Professional Standards Review Organizations, or PSROs.
60. Copy: Standard of Care, Price Guidelines	60. PSRO's try to assure uniform standards of quality of care, and, in addition, they try to establish price guidelines for routine medical services.
61. Blind liberty, scales of Justice	61. And, as jurors, individuals should remember that we, consumers, ultimately pay those huge damage awards,
62. Secretary w/Bills Reflect Premium Costs burnt through	62. Because we share in the high cost of medical malpractice insurance, for it is reflected in bills that we pay.
63. 2-Way split: technician, Hospital w/Budget Review burnt through	63. Hospitals and other health care facilities should continue doing prospective budget reviews;
64. Hospital annual report	64. They should continue to emphasize sound fiscal management;
65. 2-Way split: Nursing center, lab shot	65. And they should continue to cooperate with other area facilities in planning for enough, but not too much, capacity and equipment. (Pause)
66. Money w/Quality of Care, Affordable Price burnt through	66. We all want and need quality health care at an affordable price.
67. Many individuals	67. We all agree that medical care should be available to all.
68. Man w/foot on desk	68. And now we must make the personal, individual commitment necessary
69. US map w/100 percent Covered, Costs Controlled burnt through	69. To make sure our collective goal is reached.

70. Crowd w/Reward Worth Effort burnt through	70. The reward will certainly equal or even exceed the effort required—
71. Graph	71. A lower total health care tab means smaller individual shares in the cost of sharing risks.
72. Copy: Lower Premiums and/or Smaller Tax Bills	72. And that means lower premiums and/or smaller tax bills.
73. Group plan brochure	73. And since, for many, insurance coverage is at least partially paid for by employers,
74. Paycheck	74. It could mean bigger paychecks because less employer money spent on insurance
75. Bigger paycheck	75. Translates into more to spend on salaries or on more competitively-priced products, which also contribute to higher incomes. (Pause, music up)
76. Graphic: Win-Win	76. Quite simply, individual efforts to control health care costs create a win-win situation.
77. Copy: Quality, Access, Flexibility, Costs	77. Quality goes up; access improves; regional flexibility is maintained; costs are controlled.
78. Copy: Risk-Sharing	78. All it takes is an awareness of and a commitment to the basic concept of risk-sharing,
79. Several individuals	79. And individual efforts toward meeting our collective goal.
80. Produced as a public service by the National Association of Life Underwriters/NALU Seal	

STATEMENT OF RANDY A. FREUDIG, RHU, FIRST VICE PRESIDENT, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS

Mr. **Freudig**. My name is Randy Freudig, here today as the spokesman of the National Association of Health Underwriters.

We were founded in 1930 to represent the interest of the health insurance sales agent to establish and maintain high standards of ethical business practice and continuing education for the purpose of providing the public with health and disability insurance coverage.

I am, and have been, a health insurance agent specializing in health insurance coverage for many years. I own and operate my own agency, R. A. Freudig & Associates, in Warrington, Pa. Our agency services over 2,000 insureds, who have approximately 3,000 dependents, which means that over 5,000 members of the NAHU have their health insurance through my office.

On behalf of the over 2,000 members who have earned the designation of Registered Health Underwriter [RHU], I am honored to be given this opportunity to express the views of the field agent on the bills proposed in Congress to stimulate competition in the financing and delivery of health care.

We who compete in the marketplace every day do not agree with the premise embodied in these so-called procompetition bills that there might be a lack of competition in the financing side of health care. I can assure this subcommittee from my everyday experience of facing competition from hundreds of agents and health insurance companies, the Blue Cross, Health Maintenance Organizations, and self-insured plans in the State of Pennsylvania, that competition in the financing side of health insurance is abundant.

We therefore recommend that the Subcommittee on Health reports to the Congress that there is no necessity to legislate in order to stimulate competition among health insurers and other institutions engaged in the reimbursement of the cost of health care.

Accordingly, we believe that those procompetition bills which establish the Government as a source of health insurance, operating as an insurance company in competition with the private sector for group and individual health insurance, should be rejected by the subcommittee. Evidence that Government is inherently an unfair competitor can be readily seen under three decades of experience with California and New Jersey State disability insurance laws.

These two States established State disability insurance funds to compete with the private sector and through the expedient of deficit financing and millions of dollars in transfers from other Government funds have almost wholly in one State monopolized the so-called competitive temporary disability benefits markets.

For more details on this takeover by Government, we recommend you to testimony presented to the Subcommittee on Health on February 21, 1980, by the Insurance Economics Society of America. The testimony appears in the record identified as volume 2, serial 96-91, pages 705 to 715.

NAHU believes that while the country does not need major legislation to stimulate the abundance of competition that exists in the marketing of health insurance plans, there is a need for appropriate legislation at the Federal and State levels to correct the inequitable and unfair hospital billing methods being used against the health insurance companies we represent to the American public. In short, our plans are overcharged by the providers of health care, which places an unfair burden on us in the competition for health insurance business.

We believe the major cause is that the Federal Government does not pay the full cost for medicare and medicaid patients. We believe it is because Congress, through the hospital-defined retrospective reimbursement system used by medicare, title 18, and medicaid, title 19, has forced an artificial hospital pricing system to exist. During the 15 years since these laws were passed, hospitals have been financially squeezed by the Federal Government cutting back on cash flowing to hospitals by Government interpretation of the defined cost now being paid by medicare and medicaid.

At the inception of medicare 15 years ago, Congress was quite clear; the program should pay the cost of care for its beneficiaries, it should not be subsidized by other patients, nor should it subsidize care to others. Yet the ink was hardly dry on the law before defined cost definitions and regulations made it clear that cost to the Government was something significantly less than full economic cost which hospitals were necessarily reflecting in their patient charges.

As hospital costs have risen, medicare and medicaid expenditures have been curtailed without service benefits being reduced. Many components of the original cost formula have been redefined to lower payments to hospitals.

The result has been that hospitals have had to make up for deficits caused by underpayments of cost by increasing the hospitals' pricing of services to prices disproportionally higher than they would be if every payor were paying the same prices for the same services. This is called cost shifting.

According to a study released by the Chicago Hospital Council late in 1980, the cost shift amounted to $91 million a year. The council stated that the companies we represent and private patients had to pay for this shortfall; that is the $91 million was shifted over to the private sector. The Hospital Council said: "This (medicare/medicaid) underpayment results in an average surcharge to other third party payors and private patients of $67 per patient day."

NAHU's research has been unable to uncover the full amount of the medicare/medicaid cost shift. But if $67 per patient-day underpayment of medicare/medicaid is shifted to private insurance plans and private patients throughout the country, this total amount of costs shifted runs into billions of dollars which our policyholders must share.

To add to the hospital costs which are being shifted to the costs of the insurance plans we market, because of medicare/medicaid policy, we find that many Blue Cross plans receive sizable hospital discounts from hospitals which are not permitted to our companies and our insureds. We believe it is necessary to correct this inequity in the areas where it is prevalent.

In the States which have so legislated, fair competition now exists between our companies and the Blue Cross plans and only the unfairness of medicare/medicaid reimbursement policy remains. From my experience in the field in Pennsylvania, the B.C. discount, I must compete with, ranges from 15 percent in the country to 40 percent in the inner city.

The National Association of Health Underwriters has established national and State committees on cost shifting and procompetition. We believe that equity in the marketplace is the only solution. All providers of hospitalization coverages must pay the hospitals the same prices for the same services. Medicare, medicaid, all Blue Cross plans, HMO's and cash-paying patients and their insurance carriers must pay the same rates for the same services.

If discounts are deemed necessary, NAHU recommends that all carriers must be allowed the same discounts provided they are willing to comply with the qualifications for obtaining the discounts.

Our National Committee on Cost Shift and Procompetition will submit to this Subcommittee on Health additional information on these important subjects as it is developed by the work of our State committee.

I wish to thank the Subcommittee on Health for hearing the health insurance underwriters' concern for the elimination of cost shifting and hope that Congress will see fit to restore equity to the marketplace.

Chairman Jacobs. I hate to tell you, sir, but you went over 2½ minutes. I caution the witnesses in consideration of those way down at the other end of the line, in the Marine Corps they call them "feather merchants." Please be concise.

STATEMENT OF BURTON E. BURTON, SENIOR VICE PRESIDENT, AETNA LIFE AND CASUALTY, ON BEHALF OF HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. BURTON. Mr. Chairman, my name is Gene Burton, senior vice president of Aetna Life and Casualty. I appear today together with Jack Ahearn of Aetna, on behalf of the Health Insurance Association of America. We will be brief.

Our overriding concern with all the consumer choice bills produced to date is that they fail to recognize that congressional stimulants of one kind or another to competition in the financing sector will not, in themselves, change either the behavior of consumers or providers or generate new competitive forces in the health delivery system.

Whether or not more competition among providers would produce cost containment, we see no reason to believe that these bills would result in increased provider competition.

Instead, these bills, in varying degrees, rely heavily upon changes in the insurance system. For this reason, we believe several of our observations should be of particular interest.

Some of the major features common to all the procompetition proposals either would not accomplish their objectives or would be counterproductive in terms of cost or the need for additional regulation.

Our written statement submitted in advance provides more detail, so we will simply highlight our concerns here.

Regarding the first of these major features, the tax cap, the cost of health insurance varies widely by geographic area and by the ages of covered persons. We are concerned that the highly area-sensitive and age-sensitive nature of health care costs will produce inequitable results in any uniformly applied tax cap.

On the other hand, if these variables were to be factored in, the resulting tax provision would be enormously complex to administer and regulate. Tax cap proposals also ignore the tremendous difficulty of computing plan costs for the great variety of insured and uninsured benefit plans and financial arrangements available in the market today.

With respect to the second major feature, employee rebates, adverse selection, in combination with the increasing number of two-worker families, with each worker covered by a different employer's plan, will frustrate the objectives of the sponsors while at the same time adding to the cost of employer benefit plans.

Our considerable experience with FEHBP illustrates the consequences of adverse selection. Aetna's high option plan in 1978 had an actuarial value only 9 percent higher than our low option, but our claims experience for the high option for that year was 47 percent greater.

The difference is attributable to selection of the high option by those who expect to utilize more medical services.

Most important, if the tax cap and rebate provisions were to be adequately refined to reflect all of the necessary age and area variables, almost no one would be sufficiently induced to select a low-cost plan and the desired behavioral changes would not be given a chance to develop.

Multiple plan choice, the third common feature of these bills, when combined with rebates, would significantly reduce the economies of scale available from group insurance today and would increase both employer administrative expenses and insurer marketing costs.

Multiple choice would reduce the influence and hence the interests of employers in the cost effectiveness of any particular benefit plan.

It would also appear to call for a Federal definition of minimum plan benefits, with attendant regulation and restrictions on employers and insurers, which would be counter to the desire for decreased regulation in this field.

These are some of our major problems with these proposals. Equally important, in our opinion, however, are the points not addressed by consumer choice legislation. None of the bills introduced so far fully recognizes the barriers to competition and innovative benefit plan design in the present marketplace.

In order to assure the ability of insurers to meet their obligations and to protect the interests of covered persons, the States stringently regulate the business of health insurance.

This regulation, because it does not apply evenhandedly to all entities that offer health benefit plans, often frustrates fair competition.

For example, employers that self-insure employee welfare benefit plans are exempted from State regulation by the ERISA preemption clause. Noninsured plans are not subject to the myriad legislative and regulatory requirements imposed upon insured plans.

These requirements, which vary considerably from State to State, typically include a wide range of mandated benefits, free choice of provider provisions, and continuation of coverage and conversion options which are often quite costly.

Employers may avoid these obligations as well as the necessity of maintaining reserves and paying premium taxes simply by not insuring their plans.

Nor does State legislation apply equally to Blue Cross and insurers. Blue Cross plans are exempt from State premium taxes—generally 2 to 3 percent—in about 34 States and exempt from State corporation business income taxes and State and local property taxes in about 46 States. Also, of course, Blue Cross enjoys exemption from Federal income taxes.

Conventional insurance plans could not compete in an environment which requires only insurance companies to be chartered and licensed, to meet capitalization and reserve requirements, to pay premium taxes and assessments to guaranty funds, to be subject to State rate regulation and to meet the requirements of mandated benefit, continuation, conversion and provider coverage laws.

Moreover, some of the present State insurance laws regarding practitioners make it difficult for insurers to adapt their plans to a changing marketplace.

Those with whom we compete: Blue Cross, self-insured employers and HMO's, generally escape almost all of these provisions.

To go on, any discussion of competition in health insurance must also include a recognition of the multiple effects of the Government's cost reimbursement system on the private sector. Unless the shortfall created by the medicare cost reimbursement system is addressed, we believe a medicare voucher system would either require hospitals to accept less than full payment of charges from private insurers or would require medicare beneficiaries to pay substantially higher premiums to private insurers in order to get coverage equivalent to medicare.

Moreover, all private payers do not share equally in the Government program shortfall today. With respect to most subscribers, Blue Cross organizations negotiate arrangements with hospitals that avoid paying for certain elements of hospital costs.

As a result, in many markets, it has become virtually impossible for commercial insurers to compete for business with Blue Cross. In short, any equitable legislation intended to foster competition must require the States to impose equivalent regulation and taxation on all plans and delivery systems and should reduce or eliminate the Government program differential in hospital reimbursement.

To summarize, our major concerns are that all the consumer choice measures would be highly disruptive and cost-additive. They involve a great many untested economic assumptions about the medical care system and they provide little assurance of long-term reform or savings.

In our written statement, we have recommended a series of studies and demonstrations to test these assumptions. We believe such studies are essential because while we applaud the intentions of the proponents, we would caution against moving too quickly from concept to implementation.

Thank you.

[The prepared statement follows:]

STATEMENT OF BURTON E. BURTON, SENIOR VICE PRESIDENT, AETNA LIFE AND CASUALTY, ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

My name is Burton E. Burton. I am Senior Vice President of Aetna Life and Casualty. I appear today on behalf of the Health Insurance Association of America and am joined in this statement by the American Council of Life Insurance and the Life Insurers Conference.

As one of the major components of the private health-care sector, the Association has long been deeply concerned about, and has sought both private and public solutions to, the rising cost of health care in this country. The major contributors to this escalation since the mid-sixties have been general inflationary pressures and increasingly expensive, but improved, technology. Other factors have included the increased supply of hospital beds and increased utilization of health care services, in part attributable to the demand for broader insurance coverages.

Among the legislative approaches to contain health care costs which our industry has supported are the Comprehensive Health Planning Law, the Professional Standards Review Organization Law, the Health Maintenance Organization Law, and state prospective hospital budget review legislation. The voluntary approaches which we have supported include the "Voluntary Effort" initiated by the providers of care; local coalitions involving providers, insurers, and employers; a special demonstration project in Milwaukee, Wisconsin; and a variety of insurer cost containment activities. These include utilization review programs, analysis of provider charges and claim data, changes in insurance plan design to stimulate greater consumer awareness (including deductible and copayment), coverage of ambulatory surgery, hospital pre-admission testing, skilled nursing home and home care, and disease prevention and health promotion progams to promote healthly lifestyles. Through a national advertising program, we have called the public's attention to the need for our country to address the problem of rising health care costs and to the various private and public solutions which are available.

During the past few years, a relatively new concept for containing health care costs has emerged. This concept, as it initially appeared, was based on the premise that legislation in the health care sector has not succeeded in restraining costs, and that voluntary efforts have also failed because the health care system is not competitive. What is needed, say the proponents of this concept, is to make the providers of health care more competitive. They advocate, among other things, the creation of a nationwide network of HMOs, IPAs, and other forms of limited provider entities, which would compete with the present fee-for-service system. Such competition, under this theory, would operate to de-escalate the rising costs of health care.

Unfortunately, as this concept was translated into a series of legislative proposals, such as S. 139, S. 433, and H.R. 850, its original focus has changed. The bills introduced to date seek to further increase competition among insurers and insurance plans rather than directly among providers. Moreover, with regard to the insurance industry, rather than reducing regulation, the bills would result in greater regulation. They could not be implemented without the creation of a massive new federal bureaucracy.

The HIAA is opposed to all of the so-called "pro-competition," or "consumer choice," legislation introduced to date. The HIAA believes the implementation of these proposals would create serious administrative, regulatory, and economic problems without making a significant contribution toward solving the problem of cost containment.

Before considering specific provisions of pending consumer choice bills, it is important to make two critical observations about the existing health care marketplace which those bills ignore.

COST SHIFTING

In order to achieve a truly competitive environment, any consumer choice bill must correct the major inequities and impediments to competition resulting from cost shifting.

The Federal and state governments do not provide full reimbursement to hospitals for the expenses incurred by Medicare and Medicaid patients. Many Blue Cross plans have similar cost-minus reimbursement arrangements with hospitals. Therefore, hospitals are forced to shift the losses incurred under these programs to the patients of insurance carriers. During 1979, $3.0 billion was shifted from government programs to the private sector. Based on recent trends, this is estimated to reach $4.8 billion in 1981. Cost shifting of this nature is a severe impediment to competition. It further exacerbates the problem of inflation for the non-government sector. Government underpayment of Medicare and Medicaid costs particularly intensifies the financial problems of inner-city hospitals which do not have a broad base of charge patients to which costs can be shifted. This problem should be addressed by the Congress if it seeks to enhance competition in the private sector.

It is noted that the Federal government, by law and regulation, and Blue Cross Plans because of their bulk buying power in a given state, and, in certain states because of special state laws, can obtain these cost reimbursement arrangements. Insurance companies cannot do so because it is illegal, under the antitrust laws, for them to join together and negotiate lower rates with providers. Further, there is no single insurance carrier, in any given state, with enough buying power to exercise sufficient economic influence on the providers of that state to obtain lower rates.

CURRENT COMPETITION IN THE INSURANCE INDUSTRY

Private health insurance is currently one of the most competitive industries in the country. It is largely marketed through a group mechansm wherein sophisticated buyers (unions and employers under collective bargaining) purchase their coverage from one or more of the competing carriers.

Already, over 700 private insurance companies in the United States write individual and group health insurance. They operate in competition with 70 Blue Cross and 70 Blue Shield Plans, other hospital service and medical society plans, an increasing number of health maintenance organizations and similar group prepayment arrangements, a variety of uninsured plans sponsored by employers and labor unions, and a miscellany of other plans operating under the auspices of consumer cooperatives, fraternal societies, and so forth. In 1980, the largest insurance company accounted for 4.4 percent of the total business. The top four firms had 12.6 percent of the total premiums, and the top eight firms had 20.1 percent. (In 1970, the largest company had 5.2 percent, the top four combined had 17.4 percent, and the top eight combined had 26.5 percent.

A relatively new and rapidly expanding area of competition has developed as a result of the trend toward providing health benefits for employed groups through arrangements whereby the insurance risk is assumed in whole or in large part by the employers, who often contract with an insurance carrier or other organization to handle the claims and administrative services. More than 34 percent of the business handled by HIAA member companies was written on this basis during 1980.

The HIAA believes that, rather than enhancing the competition that exists today in the already very competitive insurance industry, the current proposals would be destructive of competition by destroying the group insurance mechanism which has lead to today's competitive market.

While the various bills introduced to date vary in detail, current discussions center around proposals to limit the employee income tax exclusion for employer health plan contributions, proposals, to require employer plans to offer employees multiple options with a cash rebate to those taking a lower-cost option, and proposals for a Medicare voucher system.

THE TAX CAP

The proposals under consideration would put a dollar limit, or "cap", on the current exclusion from employee income of employer contributions to an employee group health insurance plan.

The sponsors' presumption is that many employees would seek to avoid paying taxes on imputed income resulting from employer contributions in excess of the maximum contribution level. They anticipate that employes would therefore choose a plan costing less than the maximum contribution level. But such employee action appears doubtful. Because no individual is in a 100 percent tax bracket, it would seem more reasonable that employees would rather receive the benefit and pay tax on it than forgo the benefit. Witness, for example, employee willingness to accept group life insurance coverage in excess of $50,000 even though imputed income results.

A single national tax cap for employer contributions also fails to recognize that medical costs, and therefore plan costs, vary widely both in geographical area and by age composition of employee groups, among other factors. A single national tax cap, set at a realistic level to accomplish its purpose, would necessarily discrimination against employees in high medical cost areas and those in groups with higher than average age. A single national tax cap may discourage the employment of older workers. Conversely, it would allow tax-free purchase of much more generous benefit plans by young groups and those in low medical cost areas.

These consequences could be avoided by varying the tax cap according to geographic area and age. This would, however, greatly complicate administration, and would reduce the number of individuals electing low-cost plans. It would also introduce potentially undesirable variables into the federal tax code.

Currently most employees are covered by insured or self-insured group plans which are experience-rated. The task of devising individual premiums for all employees under widely varying plans is enormous and complex. What expense elements should be used; how should administrative costs, overhead, cost of reserves, taxes be factored into the "premium"?

The cap may also be a disincentive to development and growth of new types of benefits, such as dental care, vision care, "wellness" and preventive benefits, and mental benefits.

MULTIPLE-CARRIER RULE

In addition to requiring that employers, if they have an employee health plan, must offer three different options, where available, some proposals require the options must be from three different carriers. Presumably, .the three-carrier rule is intended to increase competition among carriers. Besides the lack of demonstrated need for increased carrier, as opposed to provider, competition, there is reason to believe such a rule would have many unintended adverse effects. For example:

1. The administrative costs of multiple plans would increase employer costs as the economy of scale is reduced.
2. Employer bargaining power with respect to any individual carrier would be reduced since the employer must offer three.
3. Carrier uncertainty about the size and composition of the employee group to be insured may lead to higher rates and more restrictive underwriting.
4. Multi-state employers may need many more than three carriers to comply with regard to employees in each of various different locations, adding further cost and complexity.
5. The multiple carrier rule may be a disincentive for insurers to develop and experiment with new or innovative alternative delivery systems which cannot be marketed effectively to their own customers.
6. Added costs and complexities may create a significant incentive for employers to offer no health plan, thus increasing the population with no insurance.

THE CASH REBATE

While requiring the employers to offer three plans, the proposals require the employer to make an equal contribution for all employees with a cash rebate to any employee taking a plan costing less than the employer contribution. Presumably less expensive health plans will have greater individual risk sharing and thereby moderate demand for health care. However, when it comes to health benefits coverage, Americans tend to be highly risk-averse. Most people seem to prefer broad, comprehensive coverage, even with respect to individual health insurance and Medicare supplements, neither of which is signficantly tax-subsidized. Given this prevailing attitude, we should consider carefully who is most likely to choose a lower cost benefit plan and why.

ADVERSE SELECTION

Adverse selection is a term which describes the completely normal behavior of a buyer appraising the value of a product or service. When faced with a choice between products, the thinking consumer will try to determine "which one is the most advantageous purchase for me?"

In insurance, it is a fundamental principle that adverse selection must be controlled, or at least limited, if the financing of an insurance plan is to be actuarially sound. Life insurance, for example, cannot be sold at the same rate at all ages.

The rebate of the difference in cost between high- and low-cost plans supposedly provides the motivation to choose the latter. However, individual employees will select the plan which appears more advantageous to themselves and their families. An employee will weigh the value of the additional coverage of the higher option against the amount of the rebate for the lower option. Based on family health status, employees who expect large medical expenditures in the near future will tend to select the most comprehensive benefit plan available. Employees who do not anticipate large expenses will tend to choose a lower cost plan so long as the difference in cost is an attractive inducement.

The premium rate for a group plan is a composite of the rates applicable to each employee and dependent enrolled. (Age rates are lowest for young persons and highest for older persons.) If the amount of the rebate is based upon the composite group rate, the rebate will stimulate young, health employees to choose the low-cost plan, but will not motivate older or unhealthy employees to forego the high-cost plan.

The principal effect of the tax cap with rebate, therefore, may be that the lower cost plan will be selected most often by young employees, except those who are unhealthy; and the higher cost plan will be selected by unhealthy employees of all ages and by older employees regardless of their health.

To compensate for the tendency of younger employees to choose low-cost plans, an age factor could be computed into the refund calculation. Medical benefit plan costs vary by geographical area. To maintain equity, these cost variations could also be reflected in the determination of the refund. However, these complexities would introduce further administrative difficulties and reduce incentive for employees to elect low-cost plans.

In addition to recognizing age and geographical area in calculating the rebate, it would be necessary to introduce controls against the adverse selections that would occur if employees are free to switch their enrollment between options whenever their health status changes. If adjustments and controls are not introduced to control adverse selection, the high-cost plans will attract the older, less healthy lives, and premiums for the high-cost plans will increase to reflect their experience while low-cost plan premiums will decrease. As the difference between plan costs widen, even fewer younger, healthier employees will choose the high-cost plan, both because it is too expensive and because the rebate grows larger.

Consequently, the cost of the high-cost plan will, over time, increase disproportionately and be more likely to exceed the tax cap, resulting in taxable income to the older, less healthy employees, while younger, healthier employees would receive a windfall rebate. Ironically, in plans jointly funded by employer and employee contributions, part of that rebate will come out of the pockets of the older, less healthy employees.

Evidence for "adverse selection" is contained in the experience of the Federal Employee Health Benefits Program and the experience of the employees covered by the State of Colorado.

According to a recent Blue Cross/Blue Shield publication:

"The Blue Cross and Blue Shield FEP high-option benefit package is considerably less than double the low option's actuarial value. Thus, if the populations served were identical, the high option's claims cost should be less than double that of the low option. Actual claims costs per high-option enrollee, however, are more than double the claims costs per low-option enrollee. There clearly is higher utilization by those choosing the high option, i.e., adverse selection has taken place. As a result, experience rating has produced a 1981 high-option family rate of $1,720, more than double the low-option annual family premium of $743.

New enrollees who opt for the Blue Cross and Blue Shield federal employee's high option during open season, dropping another carrier's plan, have claims costs during their first year in the Blue Cross and Blue Shield federal employee high-option program which run 145 percent of the average enrollee in the same program. Those who choose to leave during an open season have had claims that are only 65 percent of those of the high-option group as a whole."

The Government-wide Indemnity Benefit Plan, administered by Aetna Life and Casualty, had similar experience. For the year 1978, the actuarial value of benefits under the High Option was 9 percent more than the Low Option. However, after removing the impact of differences in census composition (age-sex) between the two groups, the actual level of claims paid under the High Option was 47 percent higher than under the Low Option.

In another example, the State of Colorado offered employees a choice of high or low options from 1966 until the high option was terminated in August 1979. Shortly after the mid-1970s the cost of the high and low option plans grew farther and farther apart. They continued to do so until the high option was terminated in August 1979. At that time, although the average actuarial value of the high option was only 22 percent greater than the average actuarial value of the low option, the average claim costs per high option employee were 237 percent higher than those for the low option employee.

This disparity between actual claim costs and actuarial values of the plans is a graphic illustration of the potential adverse consequences of a full, unadjusted rebate for employees electing the low option.

Thus, introduction of multiple insurance plan choice, in conjunction with rebates, will not reduce aggregate health plan costs but may actually increase them. The employer's cost is always the cost of the high-cost plan times the number of employees, since the rebate must be added to the cost of the low-cost plan. If adverse selection drives up the per-employee cost of the high-cost plan, the employer's total cost goes up accordingly.

This strongly suggests that the rebate should not be the full difference in cost between the plans, but should be reduced so as to approximate the actuarial value of the benefits foregone. Such in the rebate would enable the employer contributions and the employee high-cost plan contribution to be restrained from rising. In theory, this is an acceptable solution, but, because it requires a determination of what the actuarial value of each benefits plan would have been had all employees enrolled in that plan, it presents formidable administrative complications. Furthermore, a reduction in the rebate also reduces the incentive to choose the lower-cost plan.

TWO-EARNER FAMILIES

Assume that both spouses in a family work in companies offering comprehensive plans to which employer and employees contribute. Currently, they would probably decide which plan offered better coverage and enroll the family in that plan. Alternatively, both might elect coverage in their respective plans, in which case a standard employee benefit plan provision (known as Coordination of Benefits, or COB) designed to prevent overinsurance, would reduce the cost for both employers by assuring that the combined benefit from both plans does not exceed 100 percent of the employee's medical expenses.

However, if multiple-choice with rebates are introduced, it then becomes advantageous for both spouses to choose the low-cost family plan of their respective employer. Despite COB, they could continue to enjoy full coverage, equivalent to or even exceeding the comprehensive plan, and receive two rebates as well. Avoiding double rebates and coverage would be difficult and complex.

MEDICARE VOUCHERS

Part of the discussion of consumer choice proposals has included the concept of the federal government providing Medicare beneficiaries with vouchers to purchase private health insurance policies as a means for stimulating greater competition in the health care system with the aim of reducing the escalation of health care costs.

Among the concerns which we have with respect to the voucher idea are:

1. Under the Medicare Program, as presently constituted, providers are reimbursed at less than full charges, in accordance with regulations unilaterally estab-

lished by the government. Insurance companies do not have the advantage of such reimbursement arrangements with providers. Latest SSA data indicate that Medicare reimbursement averaged 17 percent below hospital billed charges in 1979, and the most recent cuts in the budget reconciliation bill will increase the differential. It is impossible for the savings achieved through private administration to offset the substantial reimbursement advantage of the government program. Hence, private carriers could not deliver the same benefits for the premium provided. Thus, unless some change is made in the reimbursement arrangement, insurance companies could not offer medical expense policies which would be competitive with either Part A or Part B of the Medicare Program.

2. Under proposals advanced to date, Medicare beneficiaries would be offered the opportunity of utilizing a voucher roughly equivalent to the average per capita cost of Medicare to obtain a private insurance policy, but they would not be required to do so. Those Medicare beneficiaries who do not utilize the voucher would remain under the government program. Assuming the problems of differential reimbursement cited above were resolved, it is likely that the younger beneficiaries, for example, from ages 65–74, in relatively better health, would be more likely to choose to be covered under the voucher system, while the older beneficiaries, again, for example, from ages 75 and above, in relatively poor health, would remain under the government program because their vouchers could not purchase equivalent private coverage. This anti-selection would result in greater per capita costs to the government program. There is likely to be additional anti-selection inasmuch as beneficiaries using vouchers may come, largely, from geographical areas where the average per capita cost of Medicare is below the national average.

3. Several proposals have advanced the concept of separate rating by age, sex, institutional status, disability, health status, and geographical area in order to offset the concern cited in (2) above. These proposals would require considerable additional regulatory authority to assure uniform and equitable application of such measures and thus would add to the burden of federal and state regulation of the insurance business. The cost of monitoring the carriers, HMOs, and other entities involved could be substantial.

4. Providing vouchers for Medicare beneficiaries to stimulate competition, while at the same time retaining the government program for those who do not choose the voucher system would result in a net increase in administrative costs. The administrative mechanism for the government program would be retained at the same time that private administration would be instituted, with a further increase in funds for regulatory oversight. More importantly, the government program would "compete" with private programs under rules established and subject to change by the government. Experience has shown that in such a situation private plans are driven from the market as social and political pressures force the government to keep its program costs artificially low.

FURTHER STUDY NEEDED

We urge Congress to consider demonstrations to examine various methods of changing health care, financing, delivery, or pricing to achieve cost containment results. In many instances, existing arrangements can be studied, which would speed resolution of issues. Areas which need study include:

1. Study existing multiple choice plans to determine if wide variations between actual high and low option plans experience (as compared with smaller difference in value of benefits as determined by manual rates) is due to adverse selection or cost effective behavior.

2. In many areas Blue Cross and Blue Shield plans and HMOs have negotiated discounts from established provider charges as the basis for payment. As negotiated arrangements are a key ingredient of the consumer choice proposals, these arrangement should be studied to determine:

(1) whether they are economically justified; and

(2) their effect on competition between Blue Cross Blue Shield plans, HMOs and insurance companies.

3. Competition legislation is intended to encourage the development of limited provider plans in which a provider's income depends upon plan utilization. Ethical and conflict of interest questions are posed by such arrangements. Study should be made of treatment patterns under such arrangements with particular emphasis on the treatment patterns of providers participating in such limited provider plans who also treat patients of freedom-of-choice plans. Study should also include examination of the pricing pattern of providers who participate in limited provider plans. 4. Study should be made of the antitrust and price fixing implications of provider controlled IPA plans which encompass a substantial percentage of community practitioners.

5. Study the impact of employee plan elections in existing multiple choice employer plans, including those which provide for equal employer contributions regardless of employee plan choice.

6. Study the expected administrative costs under various consumer choice proposals (including regulatory costs of government and private organizations.)

7. Develop demonstration projects on provider reimbursement and study impact of existing provider reimbursement arrangements such as New Jersey Diagnosis Related Grouping's approach.

In summary, we believe that implementation of the current consumer choice proposals would be costly and complex without achieving the desired results and urge enhancement of competition in the present system through equality of taxation and regulation among health insurance competitors and reform of the present cost reimbursement systems of health care financing.

Chairman **Jacobs**. Thank you, Mr. Burton.

Mr. McNerney.

STATEMENT OF WALTER J. McNERNEY, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

Mr. **McNerney**. Thank you, Mr. Chairman. I will be brief.

We have already submitted a complete statement and two papers, one on consumer choice and one on medicare vouchers. I would appreciate it if they would become part of the record.

The Blue Cross and Blue Shield Associations are deeply aware of the problems that the Federal Government and all of us, for that matter, face in insuring good health care to the Nation at reasonable cost.

We urgently need to find realistic answers to the problems of service and cost. We like the philosophy underlying the procompetition proposals before this committee. The idea of greater reliance on marketplace incentives, increased competition, giving the consumer a larger role in selecting health care and health insurance are fundamentally appealing to us. Further, we believe that the private sector can be the source of innovation and serious effort to solve the problems in our health care system.

But we must observe that we also see some enormous political and technical barriers in the way. I would like to mention a few of these.

Our concerns, from a political perspective, can be stated briefly. First, it is not easy for Government to restrain its regulatory power once it has entered a field. Some regulation will be required initially, but history demonstrates that Federal regulation tends to become overly prescriptive.

Second, and even more important, we believe it will be particularly difficult to design well-balanced proposals when the political pressure to make major and short-term cuts in the Federal budget is so high.

We believe the proposals that are being debated and discussed will not work unless Government: One, finds the correct balance between competition principles and regulations necessary to protect the consumer; two, leaves insurers the latitude they need to compete effectively in the marketplace, and three, remains a responsible participant in financing the costs of health insurance for low-income and elderly Americans.

This will not be easy for many reasons. First, consumer choice and medicare voucher proposals could unleash a very rapid further segmentation of the insurance market leaving older and sicker people in prohibitively costly insurance plans as younger and healthier people gravitate toward low-cost plans.

Our experience in offering such choice to individuals within employee groups shows this type of adverse selection in fact does happen.

The extent and manner of the regulation required to mitigate this problem and the balance between competition and regulation as a result become critical.

Second, insurance markets are already highly competitive but it is very important to point out that if competition among insurers is to make a major difference in costs it must result in a shift in competitive pressure from insurers to providers of care.

To put it another way, the competition among insurers must result in premium differences based on the insurer's ability to motivate productivity in providers and negotiate favorable unit costs. It must not be based on the insurers' skill at enrolling people whose age and health status assure low utilization of services.

Third, if medicare vouchers are used to cut or cap the Federal budget, the result is likely to be vouchers whose value is too low to pay for medical benefits in the private sector. Additional out-of-pocket premiums or higher patient cost sharing by beneficiaries would be necessary to compensate for an inadequate voucher.

Mr. Chairman, medicare regulations have arbitrarily held payments to providers significantly below what most private insurers pay. We fear that in most areas of the country and for most services savings from these reduced payments exceed what could be saved by insurers through greater competitive pressure.

In effect, the voucher would have to be higher than the current average payment under medicare now required to cover the same benefits. If the voucher is set unrealistically low in order to save Federal dollars we are concerned that medicare beneficiaries will be unable to afford the higher out-of-pocket costs required and thus may be forced to go without needed health care. Moreover, the elderly will feel the Government and insurers have cheated them out of an entitlement.

Of course, as many have discussed, the public and teaching hospitals will be even more strapped under these circumstances.

Finally, there is one other aspect of this subject I should like to address. A cap on the amount of an employer's health premium contribution that is tax exempt to the employee may encourage purchase of health insurance with higher cost sharing.

If the cap were high enough we would be less concerned. But in our view excessive deductibles and coinsurance are basically inequitable because they affect those with low incomes more adversely than high-income people.

There are far better ways to discourage excessive use of hospital services. I would point out, for example, that the lowest use of hospital services is under comprehensive HMO contracts which seldom have deductibles and coinsurance.

Also, first dollar coverage gives the carrier negotiating leverage with providers that we have found helpful in obtaining lower rates for our subscribers.

Let me say parenthetically I think it is interesting to be accused of driving good bargains with hospitals, particularly when the rate is lower and benefits the subscriber. I invite our competitors to do the same thing and get the same bargains.

Finally, we fear it would be extremely difficult administratively to vary tax caps by region of the country and perhaps bring other factors as well in order to make them equitable.

I believe elements of the procompetitive proposals may have some effect on costs in the long run if the problems we have identified can be solved or at least mitigated. But, none of the current proposals would do this.

In closing, it is extremely important to put the cost issue in context. There are many reasons for rising health care costs. I should add that costs are escalating rapidly in all industrialized societies, regardless of how they organize the financing and delivery of care.

Some of the causes of cost increases—general inflation, aging of the population, breakthroughs in medical technology—cannot be remedied by competitive pressure. Others can be affected only indirectly and over time.

Arguably the competition proposals would affect the degree of utilization of services. It would affect the utilization of inappropriate levels of care and the unit price of services. But the level of savings possible here is highly speculative and most leading proponents of the bills and of the issues feel that it would take up to a decade to have substantial influence felt.

Although these procompetition proposals you are deliberating in this hearing seem to be viewed by some as a formula for major short-term savings to either the Federal Government or the Nation as a whole, I don't believe either result can be achieved.

On the other hand, we understand the budgetary pressure government is under to limit future cost of health care programs and we are committed to working with the administration and the Congress to evaluate alternative proposals. We have a number of studies underway dealing with how people choose under multiple choice situations.

We have studies underway on what the cost of voucher would have to be, to be effective, the effect of costsharing on use, et cetera.

We would be glad to share these with you. We believe that we would be willing if Government were to hold up its end to participate in some demonstrations and underwrite populations on an areawide basis to test some of the formulations that might arise out of these studies.

I would welcome the opportunity to respond to questions.

[The prepared statement and additional material follow:]

STATEMENT OF WALTER J. MCNERNEY, PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATIONS

Mr. Chairman, as insurance carriers and Medicare Intermediaries, the Blue Cross and Blue Shield Associations and Plans are deeply aware of the problems the Federal Government and all of us face in assuring good health care to our nation at reasonable costs. The budgetary problems Government faces under Medicare parallel the problems we face in our private insurance markets. In both public and private insurance programs, we need, urgently to find realistic answers to our problems of service and cost.

We are encouraged by the philosophy underlying the procompetition proposals before this Committee, but have grave concerns about some aspects.

We are encouraged by the philosophy of placing greater responsibility on the private sector for providing health insurance and addressing the problems of cost and service in the health care system. The idea of greater reliance on marketplace incentives, of increased competition, and of giving the consumer a larger role in selecting health care and health insurance are fundamentally appealing to us. We believe that the private sector can be the source of innovation and serious efforts to solve the problems in our health care system.

Mr. Chairman, if we can get to the point where we see how these proposals can be implemented effectively, we will offer our support. But, we must observe, that we see enormous political and technical barriers in the way.

From a political perspective, our concerns can be briefly stated: First, it is not easy for government to restrain its regulatory power once it has entered a field. Some regulation will be required, but history demonstrates that Federal regulation tends to become overly prescriptive. Second, and even more important, Mr. Chairman, we fear it will be particularly difficult to design well-balanced proposals when the political pressure to make major and short-term cuts in the federal budget is so high.

From a technical perspective, we believe the proposals will not work unless government: 1) finds the correct balance between competition principles and regulations necessary to protect the consumer; 2) leaves insurers the latitude they need to compete effectively in the marketplace; and 3) remains a responsible participant in financing the costs of health insurance for lowincome and elderly Americans.

This will not be easy for many reasons.

First, current consumer choice and Medicare voucher proposals could well unleash a very rapid further segmentation of the insurance market, leaving older and sicker people in prohibitively costly insurance plans as younger and healthier people gravitate toward low cost plans. Our own experience with multiple offerings to individuals within employed groups shows that this type of "adverse selection," in fact, does happen.

To limit the degree of market segmentation would require a structuring of the market through regulation to prevent insurers from competing only on the basis of signing up preferred risks, and to avoid having individuals move from low to high benefit plans only when they perceive a need for health services. The extent and manner of this regulation and its balance with competition are critical. It must apply to all insurers and self-insurers equally, and room must be left for innovation and competition. Thus far, the only way we have cound to mitigate this adverse selection, and still have multiple choice by employees, is to require that the choices be reasonably comparable in scope of covered benefits. We are exploring other approaches to this challenging problem.

Mr. Chairman, insurance markets are already highly competitive. But, if competition among insurers is to make a major difference in costs, it must result in a shift in competitive pressure from insurers to providers of care. This means insurers need to be induced to compete in major part on their ability to set up innovative or negotiated arrangements with some hospitals and physicians to offer health services to subscribers at reduced costs. If the "competition" among insurers does not achieve that objective, we will have done little to affect the cost of health services.

To put it another way, from a public policy standpoint, the competition among insurers must result in premium differences based on the insurer's ability to motivate productivity in providers and negotiate favorable unit costs, not on the insurers' skill at enrolling people whose age and health status assure low utilization of services. We would welcome increased competition on the basis of provider productivity and negotiated costs, and believe private insurers can make a difference in cost and services through such competition.

Second, let me express some concerns about the Medicare voucher proposal. If the voucher is used as a way to cut or cap the budget, the result could well be vouchers whose value is too low to pay for Medicare benefits in the private sector. Additional out-of-pocket premiums or higher patient cost-sharing by beneficiaries would be necessary to compensate for an inadequate voucher.

Mr. Chairman, Medicare regulations have arbitrarily held payments to providers significantly below what most private insurers pay. We fear that in most areas of the country, and for most services, savings from these reduced payments exceed what could be saved by insurers through greater competitive pressure. Conceding that providers need some restoration of the current Medicare reductions, the differences between the average payment of private carriers, using their own reimbursement methods, and Medicare payments would be significant. In effect, the voucher would have to be higher than the current average payment under Medicare now required to cover the same benefits. If the voucher is set unrealistically low in order to save federal dollars, we are concerned that Medicare beneficiaries will be unable to afford the higher out-of-pocket costs required and thus may be forced to go without needed health care. Moreover the elderly will feel the government and insurers have cheated them of an entitlement.

Mr. Chairman, the elderly would have no place to go in that situation. State and local government can't afford more public hosptials, and teaching hospitals would be more strapped than ever. Ultimately, we fear, federal and state regulations, through denying rate increases, might force Blue Cross and Blue Shield Plans to subsidize the voucher (as 20 states do now in Medigap policies) to a degree that will make us non-competitive in private insurance markets. In addition, we are concerned that not all of the elderly are sufficiently equipped to make good choices among insurance options and, in fact, may over-insure or possibly fall victim to profiteering by some carriers and agents.

Finally, there is one other respect of this subject I would address. A cap on the amount of an employer's health premium contribution that is tax exempt to the employee may encourage purchase of health insurance with higher cost-sharing. If the cap were high enough, we would be less concerned. But in our view, excessive deductibles and coinsurance are basically inequitable because they affect those with low incomes differently than high income people. Moreover, there are far better ways to discourage excessive use of hospital services. I would point out, for example, the lowest use of hospital services is under comprehensive HMO contracts which seldom have deductibles or co-insurance. Also, first dollar coverages give the carrier negotiating leverage with providers that we have found helpful in obtaining lower rates for our subscribers. Finally, we fear it would be extremely difficult administratively to vary tax caps by region of the country and perhaps by other factors as well in order to make them equitable to all taxpayers. The Medicare voucher proposal is also enormously complex and would face the same issues.

Mr. Chairman, the main reason advanced for considering pro-competitive proposals for restructuring the financing of health care seem to be:

One, to see if the proposals would yield greater productivity in the provision of health care services at lower cost to the nation as a whole; and

Two, to see if they would be wise and effective means of constraining the Federal Government's expenditure for health.

I believe elements of the pro-competitive proposals may have some effect in the long term on these costs if the problems we have identified can be solved. None of the current proposals would do this.

It is extremely important to put this cost issue in context.

There are many reasons for rising health care costs. (I should say that those costs are escalating rapidly in all industrialized societies, regardless of how they organize the financing and delivery of care.) Some of the causes of rising costs cannot be remedied by competitive pressure; others can only be affected only indirectly and over time. For example, the increase in the aged as a proportion of the population is a major cause of rising costs. In addition, the expansion of medical technologies and the number and configuration of providers are major causes of rising costs. But these phenomenona are relatively remote from any individual's choice of health care and health insurance alternatives. We might argue about how much the sum of individual choices in a pro-competitive system will influence the number and configuration of providers, for example. But no one would argue that increased competition would make a major difference in these causes of rising costs in the short term.

As mentioned earlier, other causes which might arguably be affected over time by such legislation are: (1) the degree of utilization of services, such as frequency of admission and length of stay in hospitals and the amount of laboratory and diagnostic work, (2) the use of inappropriate levels of care for want of better kinds or mixes or services in many communities, and (3) the unit price of services. But the level of savings possible here is highly speculative, and many of the leading proponents of the competitive model have themselves concluded that it would take up to a decade for the model to have a substantial influence on overall costs. Although these procompetition proposals you are deliberating in this hearing seem to be viewed by some as a formula for major short-term savings to either the Federal Government or to the nation as a whole, I do not believe that either result can be achieved.

Moreover, these proposals are much too important to be decided solely on the basis of short-term budget objectives.

On the other hand, we understand the budgetary pressure government is under to limit future costs of its health care programs, and are committed to working with the Administration and Congress to evaluate thoroughly the competitive proposals and other alternatives before taking a final position. We have a number of studies under way and will share them when completed in November.

I welcome the opportunity to respond to questions.

COMPETITION
AND
CONSUMER CHOICE

National Health Care Legislative Proposals

Blue Cross Association

Blue Shield Association

COMPETITION AND CONSUMER CHOICE

For more than a decade, national health insurance dominated the health policy debates. Now even its most ardent supporters consider it dormant for the forseeable future.

Instead "competition" and "consumer choice" —new ideas—have surfaced. These ideas are gaining recognition, if not total acceptance, in the current political atmosphere.

The pro-competition reformers, a group of rising and influential Senators, congressmen, and officials of the Reagan Administration want to restructure the marketplace so that health insurance benefits are selected from a range of employer-offered benefit packages by employees who have a financial stake in the cost of the package chosen. Because of the range in costs of the packages offered, the expectation is that the consumer will shop for the best health benefit value.

This paper discusses the underlying theory and key features of the pro-competition bills, points out some issues presented by the bills, suggests possible effects on the Blue Cross and Blue Shield Plans and their subscribers, and recommends some action steps to the Blue Cross and Blue Shield Associations and Plans for dealing with the subject.

What is the underlying theory of the "competition" and "consumer choice" proposals?

The pro-competition theorists believe that a large part of health care cost escalation is attributable to the current structure of health care financing. In their view, this structure insulates the consumer from the expense of health care and rewards providers for inefficient use of resources. They see the main culprits as:

1) Laws which exempt all employer-paid health benefits from personal income taxes of the employee;

2) Employer-union negotiation of health benefits which restricts the number of options available to an employee;
3) Retrospective cost reimbursement of providers;
4) Consumption or purchase decisions made by physicians for their patients under a system where the physicians have no financial risks. This, they believe, provides perverse incentives (i.e., the physician can make more money by providing or prescribing unnecessary patient services);
5) Government regulation which: a) limits the entry of new competitors into the health care market; or b) adds unnecessary reporting and other burdens which increase health care costs.

What are the key features of the pro-competition model?

Although there is much variation in the details of the proposals, generally they would all do the following:

- Provide that employees have more than one health insurance option or alternative delivery system plan from which to choose;
- Set a maximum amount of employer contribution to employee health benefits which will *not* be counted as employee income for tax purposes and, whatever employees contribute, require the employer's contribution to be the same for all options offered;
- Reward with a rebate employees who choose a plan costing less than the employer's uniform contribution;
- Tax as employee income any employer-paid premium above the tax-free limit.

Some proposals would regulate the number and type of health benefit plans to be made available. Some require that each plan provide a minimum set of benefits, including catastrophic coverage. Others require that at least one HMO be among the available choices. All are intended to make the employee a more aware consumer with a direct economic interest in the price of health benefits and the cost of health services.

What outcomes are sought by the proponents of pro-competition bills?

The overriding objectives are cost containment and greater productivity in the provision of health care.

Proponents believe that the introduction of consumer choice will at least result in lower utilization of health care services among employees who choose traditional insurance coverages since they are likely to select coverage with higher cost-sharing. The proponents are also convinced that the competitive model will stimulate consumer interest in HMOs or other organized systems which may provide more cost-effective care. A few believe the health benefit marketplace will be so transformed that insurers and providers, in order to maintain their share of the market or patients, will be motivated quickly to organize HMOs, or some other model capable of providing more care for the employee's benefit dollar.

The advocates also believe that the economic discipline exerted in this highly competitive market will substantially change provider incentives and render obsolete and unnecessary most of the government regulations imposed upon health care today.

In summary, the proponents believe that cost reduction can be achieved through marketplace forces created by the competitive model and that it will result from:

1) greater consumer acceptance of low cost insurance plans which make individuals feel the bite of health costs (through pay-

ment of co-insurance and deductibles at the time of care) and thereby reduce consumer demands for services;

2) greater demand for (and insurer or provider willingness to provide) alternative delivery systems, such as HMOs and other forms of provider organization, which are able to deliver health benefits at lower costs and save the consumer premium dollars—or win him or her rebates; or

3) increased competition among insurers of fee-for-service health care which forces them to lean harder on providers to be more cost effective, ultimately forcing the least efficient providers to change or go out of business.

Would the proposals achieve their proponents' objectives?

This is the critical question, and the plain fact is that it cannot be answered authoritatively. The competitive model never has been fully tested. Nor are there many empirical studies which can illuminate the debate.

The theory of the proposals is that individual consumers, if given a choice, will make knowledgeable and economically rational decisions that will set in motion a variety of salutory changes in insurer and provider behavior. However, there is little evidence to support claims that the pro-competitive incentives would have that effect. The debate is left largely to assertion and speculation, with economists themselves divided. One side says consumers are likely to become more knowledgeable, cost-conscious and assertive. The other side says this won't happen; health care is not a normal commodity, and individuals faced with illness and survival are not going to "shop" as they might for other commodities.

Long-range prognosis for governmental action

The pro-competitive philosophies and models will be discussed for a long time. Although a comprehensive pro-competitive bill is not likely to be enacted for at least two to four years, if ever, debates about the pro-competition concepts will begin very soon in the Congress. Perhaps more important in the short run is the fact that pro-competition philosophies are being used to justify immediate legislative proposals. The Administration proposes to eliminate the federal health planning and PSRO programs in the name of competition. As a means of increasing tax revenues, some Administration officials, the Congressional Budget Office, and some members of Congress have proposed limiting the extent to which the employer's health benefit premium payment is tax exempt for the employee. For example, a staff proposal to the Senate Finance Committee would limit the tax-free employer contribution to $120 per month for family coverage (for an estimated annual increase in tax revenues of $1.9 billion); repeal the $150 dollar income tax deduction for individuals' insurance purchases (for an annual increase in tax revenues of $400 million); and increase from 3 per cent to 10 per cent the amount of income which must be exceeded before a medical expense deduction can be made (for an annual increase in tax revenues of $2.2 billion).

The Administration and some members of Congress also are seriously considering proposals to raise deductibles and co-insurance under Medicare and to shift Medicare eligibles who still have access to private insurance out of the Medicare program and into private coverage.

If competition legislation comes piecemeal, it would probably come through one of two initial steps:

1) a limitation on the amount of an employer's payment for health benefits which is tax-free to the employee;

2) a requirement that employers must offer a multiple choice of health benefits to an employee, as already required in a limited way under the Federal HMO Act.

The pro-competition proposals are radical. Some of the proposals would immediately remove most existing regulation and throw everything into the cauldron of the marketplace. That could unleash, at least in the short run, a number of major capital development projects (especially for more hospital beds) which have been forestalled by current regulation.

Not unlike the social policy planners of the 1960s, the competitive model theorists make a series of assumptions about how individuals and institutions would behave if they were subjected to the marked change in incentives that their model would impose. Yet no one can predict with any certainty what would happen if a far-reaching pro-competition bill were enacted. For that reason, several supporters of such legislation have been searching for ways that demonstration projects might be undertaken as a basis for predicting what *would* happen. As Senator Orrin Hatch, Chairman of the Senate Labor and Human Resources Committee and the sponsor of a competition bill, put it, "we should not rush pellmell into some untested, broad-scale program." Hatch, Department of Health and Human Services Secretary Richard Schweiker, (the sponsor of a competition bill when he was in the Senate) and others have recommended that demonstration projects be undertaken.

Awareness of the radical and untested nature of the proposals is the major constraint on political action. The private institutions affected are nearly unanimous in their misgivings. However, the major political driving forces behind the proposals are formidable. Because the pro-competition approach offers the promise of savings to the federal budget and places greater reliance on market forces rather than on government regulation, chances are good for enactment of some of the elements of the overall proposals. Strong interest in the competitive strategies is certainly assured with so many of the early proponents of competition in key positions: David Stockman is now Director of OMB; Richard Schweiker serves as Secretary of HHS; David Durenberger (R-Minnesota) is the new Chairman of the Senate Finance Committee's Health Subcommittee; Orrin Hatch (R-Utah) has become Chairman of the Senate Labor and Human Resources Committee; James Jones (D-Oklahoma), Chairman of the House Budget Committee (who sponsored a competition bill in the last Congress) and Richard Gephardt (D-Missouri) remain on the House Ways and Means Committee.

What are some major issues presented by the competition and consumer choice proposals?

Cost reimbursement, fee-for-service medical practice, and the tax treatment of employer contributions to health benefits have contributed to serious escalation in health care costs. For those and other reasons, health care financing systems built up during the 1940s, 50s, and 60s must be reassessed.

The competition/consumer choice model has been proposed by many thoughtful persons. Their proposals must be carefully considered. Some of the major issues posed by the proposals are:

1. **Incentives.** Paradoxically, the pro-competition model, although anti-regulatory in intent, is also a vehicle through which the government can powerfully shape the insurance and pre-paid health care markets. If the law were to set a low limit on the tax-free employer contribution and require only minimum benefits to be offered under all employee-choice options, the government would be establishing incentives to move the market in one direction—toward higher cost-sharing and less comprehensive coverage. If the tax-free limit were set high and the

benefits were generous, the incentives would be set to move the market in another direction—toward more comprehensive coverage. Seeking the correct balance is the major task facing the drafters.

This effort will be complicated by the fact that the proponents see change coming from two rather conflicting directions. One set of proponents wants more individual cost-sharing in insurance as a means of forcing more out-of-pocket expenditures (at the time of purchase of both health insurance and health care) thereby making consumers more cost-conscious. Another set of proponents wants the ultimate outcome to be more health maintenance organization and alternative delivery systems. It may be impossible to define the rules for competition in ways which accommodate both objectives.

2. **Adverse selection.** The periodic availability to employees of a range of health benefit choices during open seasons would probably trigger what is known in the insurance business as "adverse selection." This means that individuals who anticipate greater health service demands or high health care costs for themselves or their families will tend to choose the most comprehensive higher-priced coverage available to them. On the other hand, those who regard themselves as relatively unlikely to incur heavy health care expenses will opt for less comprehensive insurance coverage.

   In public policy terms, the problem with adverse selection is that it raises the costs of insurance to those who need it most—even to the point of making it unaffordable. From an insurance standpoint, it makes it difficult to market comprehensive coverage.

   Adverse selection has been documented in the Federal Employee Health Benefits Program, often pointed to as a competitive model by proponents of the consumer choice:

- The Blue Cross and Blue Shield FEP high option benefit package is considerably *less* than double the low option's actuarial value. Thus, if the populations served were identical, the high option's claims cost should be less than double that of the low option. Actual claims costs per high option enrollee, however, are more than double the claims cost per low option enrollee. There clearly is higher utilization by those choosing the high option, i.e., adverse selection has taken place. As a result, experience rating has produced a 1981 high option family annual premium of $1,720, more than double the low option annual family premium of $743.

- New enrollees who opt for the Blue Cross and Blue Shield federal employee's high option during open season, dropping another carrier's plan, have claims costs during their first year in the Blue Cross and Blue Shield federal employee high option program which run 145 per cent of the average enrollee in the same program. Those who choose to leave during an open season have had claims that are only 65 per cent of those of the high option group as a whole.

Adverse selection also has been seen in several insurance plans written for other public employee groups across the country; in farm bureau groups of the Midwest; and in the few areas where conventional insurers and prepayment plans compete with health maintenance organizations.

Adverse selection in the insurance plans with the most comprehensive benefit options could be accelerated and intensified by providing a rebate to employees who chose plans with premiums lower than the employer's standard contribution. Taxing as personal income of the employee any employer contribution above the standard amount also would motivate employees to select a benefit package with a premium pegged at or below the standard contribution.

The intensity of adverse selection would depend heavily upon the statutory or regulatory manipulation of three features of the competitive model:

1) the figure at which the standard employer's contributionis set;
2) the frequency of and rules for open seasons during which employees could switch benefit plans; and
3) the scope and levels of coverage of the minimum health benefits which all options would be required to provide.

3. **Limit on the tax-free employer contribution.** In addition to the incentives problem described previously, there are other problems which must be considered in setting the tax-free limit on the employer contribution.

A single national limit would not take into account substantial variations in medical costs by age and region. A single national limit not adjusted for age would create inequities which favor healthier young persons. A single national limit not adjusted for location would favor those who live in low cost areas of the country.

Some of the proposals would vary the limit on the tax-free employer contribution by geographic region and age group. The Gephardt/Stockman bill, for example, would have the Secretary of HHS publish applicable "exclusion limitation amounts" which would be based upon Medicare outlays for the first three years and, after that, calculated upon the weighted average of qualified plan premiums in a healthcare area for persons in the same actuarial category, adjusted for inflation by application of the GNP deflator. Initially, amounts rebated to employees in excess of $500 would be taxed. This figure, too, would be adjusted annually for inflation.

This "tax cap" issue poses another dilemma. While a single national limit would be inequitable, a limit which varies by area and age group would make administration of the program more difficult for employers, especially for national employers operating in many locations, and make Internal Revenue Service administration highly complicated.

Finally, the proposed legislation to limit the amount of an employer's contribution to health benefits which is tax free to an employee assumes that employers pay a fixed monthly rate for single and family health coverage. *This is not a universal practice.* Insurers and employers now use a wide variety of mechanisms to price and finance health benefits.

In some cases employers take full financial responsibility for the health costs incurred by their employees on a claim-by-claim basis and contract with an organization to pay those claims for them. In other cases they combine the experience of individuals and families so there is only one rate for all employees. Another growing trend is for employers to self-insure; they develop their own benefit program and pay their own claims. These new insurance arrangements do not lend themselves to a simple formula by which an employer could determine its monthly cost per employee. This would make it extremely difficult, if not impossible, to advise employees about the tax liability of their employer-provided health benefits.

4. **The Rebate.** This feature of the competition model has received no real-life test. If the competition theory works and the employees are attracted to lower cost insurance as the means of receiving the cash rebate, the effect will be to exacerbate the adverse selection problem. Young, healthy employ-

ees will opt for a low option while employees who perceive a greater need for health care select a high option.

Some analysts have recommended that the rebate not be available to younger employees, or at least that the amount of the rebate be reduced for them. This, of course, would complicate the administration of the program and reduce the incentives for selection of a lower cost insurance option—one of the principal objectives sought by many of the competition reformers.

5. **Employers and unions.** All of the competition bills would restrict the roles of employers and unions in negotiating health benefits. Under the Gephardt/Stockman bill, the employer would be required to pay its standard contribution, if any, for *any* plan selected by an employee, as long as the plan met minimal financial and other qualifications as certified:

   a) by a Health Benefits Assurance Corporation to be created in the Treasury Department; and
   b) by the Secretary of HHS.

   The competitive model could work to lessen the interest of employers and unions in health care cost containment. If so, two of the most powerful influences on provider behavior would be diminished.

6. **Insurer Competition: the theory and the reality.** Some of the theorists believe that the model will force greater competition in the health insurance business and thereby force insurers to make providers of health care behave in most cost-effective ways. Insurer strategies might include changing reimbursement mechanisms, contracting only with selected providers, or setting up their own health care delivery organizations.

   It is likely that many carriers would choose to compete in every other way possible before resorting to the kind of negotiations with hospitals and doctors required to achieve the intended reforms. At this time, such negotiated schemes are by far the hardest to achieve and riskiest form of competition. Insurers are more likely to compete with benefit packages and coinsurance provisions tailored to an increasingly segmented market. In addition, they would be likely to trim administrative corners in their medical necessity and quality assurance activities by reducing review procedures in an effort to trim expenses and, at the same time, keep their customers happy by denying fewer claims. Insurers already face resistance from insurance purchasers if their activities in any way delay rapid service to the subscriber. Under increased competition the uncritical payment of virtually any claim submitted could even become one of the unwritten rules for success in the competition for employees' favor.

7. **Subscriber income level.** The incentives built into the competition model will probably work differently depending upon the income level of the consumer making the choice. The lower the income of the person, the more likely the person will take the cash rebate and elect insurance coverage with deductibles and coinsurance. This may be beneficial to the consumer only temporarily, until he or she becomes sick.

Coinsurance and deductibles can affect utilization of health care services by low income individuals but the reason for this is unclear. Some studies show a decline in utilization once cost-sharing is introduced. However, the same studies suggest that this decline may occur not because individuals are saved from unneeded care but because they postpone early treatment. By doing this they may require more expensive care later in their illness which, due to the requirement for co-payment, costs them more out-of-pocket than if they had sought care earlier.

8. **Impact at the upper and lower ends of the delivery system.** Barring other forms and sources of subsidy, teaching hospitals and those with high-technology research capabilities could be endangered by the competitive model. Also providers may not have the resources to carry bad debt or risk the financial uncertainty of treating all classes of consumers considered to be high-cost. These would include those chronically or congenitally disabled, those in high-risk occupations, those exhibiting poor medical histories, those with certain demographic characteristics, and those with limited ability or no ability to cost-share. If the model works, insurers would increasingly seek out low-risk subscribers. (There is some evidence to show this occurs in existing highly "competitive" environments.) The major public hospitals with a high proportion of impoverished patients would face severe problems under such a scenario.

9. **Regulation of the competition.** Many of the problems with the competition model might be ameliorated by careful drafting of laws and regulations which establish the rules of the competition. This, of course, flies in the face of the anti-regulatory beliefs of many of the supporters of the competition/consumer choice bills.

   Alain Enthoven, one of the leading advocates of the competitive model, describes this dilemma well:

   > "Most of the criticisms of the CCHP [Consumer Choice Health Plan, Enthoven's proposal] so far have come from the left, from people who believe that health care should not be in the marketplace. Now the CCHP will come under closer scrutiny from conservatives, who may want to see more freedom for the market to work. The CCHP would limit consumer cost sharing and limit the range of choice to fairly comprehensive health-

> care plans. The reasons for these constraints are primarily to limit opportunities for health plans to succeed by preferred-risk selection, to limit opportunities for consumers to take advantage of the system by buying only minimal insurance when they are well and then changing to comprehensive insurance if they become sick (a phenomenon economists call 'free riding'); to limit the extent to which sick people have to pay more for health care than healthy people do; and to put pressure on health-care plans to develop their own internal cost controls and provider incentives for economy. Some conservatives prefer greater freedom in the design of benefit packages and the use of coinsurance. To achieve lower premiums and lower public sector spending, they may be willing to tolerate more of a burden on the sick. However, these issues can be resolved by a compromise within the context of a fair, competitive market system".[1]

It remains to be seen whether the compromise optimistically predicted by Enthoven is obtainable. The focus of the competition proponents and the bill drafters over the next several months will be, to a considerable degree, on fine-tuning the bills in search of that compromise.

What would happen to Blue Cross and Blue Shield Plans and their subscribers under a competition/consumer choice model?

This is a key and problemmatical question to which no definitive and universally applicable answer can be given. The model has not been tested, and there are not enough data to predict with any precision how it would work in general, much less to predict what its exact impact would be on Blue Cross and Blue Shield Plans and their subscribers. It is fair to say that the consequences would probably vary among plans and would depend to a considerable extent upon the size of their market shares.

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[1] Enthoven, Alain C. "The Competition Strategy: Status and Prospects." New England Journal of Medicine 304 (2): 111.

The principal overall effects of the model, from a business perspective, would probably be:

1. **To open up the group market.** The consumer-choice provisions of the bills would open up our groups to competitors and their groups to us. The extent of the "opening" would depend on how the competition is structured. Some of the bills would not allow a single carrier to offer more than one of the health benefit options made available to a group.
2. **To shift the locus of responsibility for choosing health benefits from employers and unions to employees.** Most of the proposals would continue the employer-based group market, with employers and unions negotiating health benefit options to be made available to employees under a multiple choice offering. The Gephardt/Stockman bill, as described earlier would allow an employee to select any qualified plan available in the market. Under the former approach, there would be a mixed group/individual market. Under the latter, some employer-based group markets could disappear. Under either approach, insurers would have to market to individual employees who would be making the choice, with the consequences of higher marketing and enrollment costs.
3. **To provide incentives for greater cost-sharing in health insurance.** This is a clear objective of some of the "pro-competition" proponents. To the extent they win their way, our comprehensive first-dollar coverage would come under increased competitive market pressure. There is considerable evidence to show continued consumer demand for such coverage. But there is less in-

formation which can be used to predict at what point premium price differences and changed tax incentives would cause substantial movement toward cost-sharing forms of coverage.

4. **To fragment the insurance pools and promote adverse selection (unless the competition is highly regulated).** Under these circumstances, Blue Cross and Blue Shield comprehensive plans would attract the higher risks. This would have deleterious results for our subscribers and would seriously decrease the competitiveness of our traditional comprehensive, first-dollar coverage in the marketplace.

5. **To provide incentives for the development of alternative delivery systems (ADS).** As described earlier in this paper, one set of competition proponents wants more alternative delivery systems. A competition bill can be constructed to provide incentives to try to move the market in that direction. It could be done by requiring employers to make available one or more HMO options, as is done under the "dual-choice" provision of the Federal HMO Act.

   We have demonstrated our ability to move effectively in the ADS market. Forty-three Blue Cross and Blue Shield Plans sponsor HMO programs either as lines-of-business or as separate subsidiaries or affiliated organizations with a total enrollment of more than 850,000 members. Enrollment growth in Plan-sponsored HMOs since 1974 is 155 per cent while nationwide enrollment in HMOs of comparable maturity has grown only 70 per cent during the same period. In addition, 21 Plans provide services through contractual arrangements [illegible] another 27 HMOs serving 536,000 members.

   A major threat to our continued development could come from provisions in a pro-competition law which would seriously impede our ability to offer alternative delivery systems. Therefore, attempts to prohibit a carrier from offering more than one health benefit option to a group are of special concern.

6. **To change the operational and administrative requirements for doing business.** The various features of the competition model could all have significant impacts on the operating and administrative functions of the Plans. One of the tasks over the next several months will be to sort out the exact dimensions of changes in Plan and systemwide operations which would be required.
7. **To shift the spotlight of political and public accountability from health care providers to others.** Employers' and unions' interest in the cost of health benefits might be lessened, and providers might be able to escape scrutiny somewhat better than they are able to do now. Unmistakably, some of the competition theorists see the health insurance industry as the principal impediment to containing health care costs. Under a model based on insurer competition, the insurers would be out front in terms of public accountability.

Blue Cross and Blue Shield Organizations' Actions:

1. **Take a strong leadership stance.**

   It makes sense to have a good understanding throughout the Blue Cross and Blue Shield Associations and Plans of the major public policy issues presented by the competition proposals and what the proposals would mean for Blue Cross and Blue Shield organizations' business. This will help the Associations and the Plans to assume a leadership role in the public policy debates and enable us to develop responses to immediate legislative proposals which are being presented as forerunners of competition or are otherwise related to the competition philosophy.

Our assumption of strong leadership in the public policy debates is especially important since the opinions of many policymakers are in a formative stage and there is a danger that much mythology will be introduced in the discussions. We could play a strong and useful role in challenging some of the myths, highlighting problems (of the sort presented in this paper) posed by the competition model, and assisting competition proponents and others with the development of approaches to overcoming some of the problems. Blue Cross and Blue Shield organizations have much experience with and information about the nature and rationale of consumer choices and the dynamics of insurer relations with providers. Our knowledge should be used constructively in the coming public policy debates.

Our recommended approach would be to say:

"Competition and multiple-choice have already become a way of life in the health insurance industry. We welcome competition and do well in competitive environments. However, we are concerned about how procompetition bills might actually work in practical, everyday terms. Here are the problems as we see them."

This paper is a first-step in problem identification. As this analysis is discussed, revised, and expanded in consequence of reviews within the Associations and the Plans, it can provide the basis for our presentation of concerns to policymakers.

2. **Establish a working group with representation from the Associations and the Plans to study what the probable impact of a procompetition model would be on Blue Cross and Blue Shield Plans and what we would have to do to function effectively under the model.**

Such a review will help us focus more

sharply on the features which would have the greatest impact on our business. It will also assist us in making constructive recommendations to policy makers.

3. **Evolve a set of observations and principles about pro-competitive, consumer choice bills.**

For starters we suggest the following:

1. Solutions to major public issues, such as health care and cost containment, should be sought wherever possible through the private sector.
2. Private sector innovation and testing of cost-effective approaches to the financing and delivery of health care should be encouraged by government policies.
3. There already is intense competition among third-party payers. It is in the national interest for them to compete more vigorously for enrollees based on their ability to provide benefits at lower costs by making arrangements with providers that facilitate more economical organization and delivery of health care. Inevitably this will include new approaches to integrating financing and delivery that is useful to this end. Such approaches could breach the artificial wall between financing and delivery, an action long overdue.
4. Insurance and pre-payment may contribute to rising health care costs as the competition theorists suggest. But there are other important factors at work—higher personal incomes, higher prices for all goods and services, improved medical technology, and strong consumer demand for the "best" services.
5. The supply side of the economic equation is an important determinant of costs. For that reason, community-

based health planning in some form must continue for the foreseeable future as an important means of restraining unnecessary health facilities construction and renovation.

6. Competition in health care and health insurance must be structured by thoughtful regulation that sets rules so that competition works in the public interest. Otherwise, severe problems will result, e.g.:
   - Preferred risk selection by many insurers and prepaid plans.
   - Adverse selection resulting from the choices of consumers, i.e., younger and healthier workers selecting low options, thereby pulling money out of the high option insurance pools. This would leave those most in need of health care without the advantages of affordable "insurance."
   - "Free riding" as consumers move back and forth among plans in accord with their short-term health care needs—real or perceived.
   - Selection of very limited coverages by low-income people who will ultimately resort to public facilities for care.
7. A bill built on consumer preference should not load the deck. A truly competitive model must include a range of qualified coverage and allow selection of comprehensive coverage by those who prefer it. Consumer preference for such coverage in highly competitive markets remains strong.

   Competition philosophers should not preach competition and then construct proposals which would effectively eliminate the comprehensive option. Financial protection and access to care as well as cost containment should remain important objectives of health policy.

8. In designing qualified coverage, one must take into account the fact that out-of-pocket payments become a deterrent to care, particularly for lower income persons.
9. If a competitive model is adopted, it should be truly competitive. It should not lock any prepaid insurer or health care organization into one pattern of business, such as by prohibiting a single entity from offering multiple options to a single group.
10. Limitations should be placed on the number of options that employers must offer. If not, there is likely to be a chaotic proliferation of health insurance plans, at least over the short run, with attendant increases in overall costs.
11. Employer-based group insurance should continue. If it does not, employers' interest in (and considerable power to influence) health care cost containment will be lost. Furthermore, health benefits should be considered within the context of all employee benefits.

Status of Specific Competition Bills

Three competition bills introduced early in the 97th Congress are:

- H.R.850, "Health Care Reform Act of 1981," introduced by Representatives Richard Gephardt and David Stockman. (Gephardt has sought comments on the bill and intends to revise it soon for reintroduction.)
- S.130, "Comprehensive Health Care Reform Act," introduced by Senator Orrin Hatch. (This is the same bill introduced by Senator Richard Schweiker in the last Congress.)
- S.433, "Health Incentive Reform Act of

1981," introduced by Senator David Durenberger.

A comparative analysis of these bills is attached.

Representatives James Martin and James Jones also are expected to reintroduce, perhaps with some variations, their bills from the last Congress.

Few congressional proponents of the competition idea believe a bill will be enacted soon. On the other hand, "competition" is the only idea for health care reform circulating in Washington at the moment which seems to have political currency. With the strong pressure to reduce public expenditures, "get the government off people's backs," and at the same time "do something" about rapidly excalating health care costs, it is likely to be the only idea to have appeal for some time.

BLUE CROSS AND BLUE SHIELD
ASSOCIATIONS OFFICE OF
WASHINGTON REPRESENTATION

COMPETITION APPROACHES TO NHI

PROPOSALS PROVISIONS	S. 139 "Comprehensive Health Care Reform Act" as introduced January 15, 1981 by Senator Orrin Hatch (R-Utah) (formerly Senator Schweiker's bill)	S. 433 "Health Incentives Reform Act of 1981" as introduced February 15, 1981 by Senator David Durenberger (R-Minn.)	H.R. 850 "National Health Care Reform Act of 1981" as introduced January 10, 1981 by Rep. Richard Gephardt (D-Mo)
Employer Plans	All employers, regardless of size must offer employees at least one group health benefit plan for inpatient hospital services. That plan must have a 25% copayment requirement for specified medical services up to 20% of the combined income of the employee's family. If employees are unionized, employer must get this mandated minimum plan approved by the employees' collective bargaining representative. Employers of 50 or more persons must add catastrophic coverage to the above benefits. Employers of 50 or more must also provide specified minimum preventive care benefits. Employers of 200 or more persons must make available to employees a choice of not less than 3 benefit plans, each of which meets all above requirements and each offered by a different carrier.	Legislation does not require that employers provide health benefits or contribute any minimum amount if they do make them available. However, in the case of any employer providing health benefits, exclusion of benefits from employees gross income would be dependent upon meeting Act's standards for scope of benefits, family coverage and continuity of coverage. In addition, employers of more than 100 persons would be required to offer employees at least 3 qualifying plans from 3 different carriers. Employer could self-insure one of the plans. Employer contribution to any plan could not vary depending on the plan chosen, but could vary with employee's marital status and number of dependents.	Every person would be eligible for a "health care contribution" to be determined by the Secretary of HHS. Employer would not be required to contribute to employee health benefits unless they were doing so prior to enactment. As under present tax law, employer contributions could vary according to an employees marital status and number of dependents. Employers only obligation would be to announce amount of its contribution (which could not be based upon the plan selected), issue employee an official certificate identifying the employee, detailing his eligibility, and stating the maximum employer contribution. Using certificate, employer would purchase any qualified plan of his own choosing on the open market and employer would make appropriate payments.

	All employers must make a uniform contribution, if any, per employee enrolled to all health benefits plans offered. The employer contribution may not be higher than the full premium cost of the most expensive group health benefit plan in which at least 10% of its employees are enrolled. Employers of less than 200 persons could offer just one plan, which could be self-insured. Not clear whether employer of 200 or more could self-insure for any of the 3 required options.		Employees, self-employed persons, and others who make direct contributions to qualified health care plans would get a tax credit for amounts paid up to contribution amount promulgated for the year by HHS. The health care contribution amount would vary by health care area and by an individual's actuarial category. Marital status, number of dependents, sex, and age would be taken into account by HHS in setting applicable health care contribution amounts. Structure of competitive environment under H.R. 850 would make employer self-insured plans impractical, because qualified plans must offer open enrollment to persons other than a firm's own employees and because employees would still be free to purchase other plans on the open market with employer's health care contribution.
Tax Treatment	Employers whose health benefits or contributions do not meet the requirements imposed by the Act may not deduct their benefit costs as a business expense and their contributions must also be included in the gross income of their employees for tax purposes. Employees selecting qualified plans with premium lower than employers' uniform contribution must be given a rebate of the difference between the two amounts. Rebate may be cash or additional benefits and will not be considered employee income for tax purposes.	Monthly "indexed contribution amounts" would be established each year. Figures for first year would be $50 for employee only, $100 for employee and spouse, and $125 for family coverage. Any employer contribution to any employee's health benefits in excess of the indexed contribution amount would be included in the employee's gross income for income tax purposes. Any employer contribution to a health benefit plan not in compliance with the Act would also be included in employee gross income for income tax purposes.	Employer contribution to premium of a qualified plan, up to an annually established "exclusion limitation amount" would be excluded from employee income for tax purposes. Any employer contributions above the HHS announced limit would be taxable employee income. If employee selected a plan costing less than his employer's contribution, employer would pay employee a rebate of the difference between the two. Initially, up to $500 of that rebate would be tax free ($500

	Sen. Hatch (S. 139)	Sen. Durenberger (S. 433)	Rep. Gephardt (H.R. 850)
		Employees selecting coverage costing less than their employer's actual contribution would receive a rebate in cash or additional benefits of the difference between their coverage premium and the employer's contribution. The rebate would be subject to federal income tax but not other payroll taxes, e.g., Social Security, unemployment compensation, or railroad retirement.	figure would be adjusted annually to account for inflation). Employees who purchase qualified plans costing more than their employer's contribution would receive a tax credit for the difference, up to the exclusion limitation amount. The exclusion limit would be based initially on the health care contribution amounts calculated by HHS for Medicare beneficiaries. Persons self-employed and others purchasing qualified Plans on their own would get same tax treatment. If amount of tax credit exceeded a person's tax liability, he would receive a tax refund. For tax purposes, collectively bargained agreements entered into before January 1, 1981 would be grand-fathered until the annually adjusted exclusion limit surpassed the employer's contribution. Payments by individuals to a qualified plan could not be counted toward existing medical expense income tax deduction for amounts in excess of 3% gross income.
Required Benefits	All employers, regardless of size, must offer at least one group health benefit plan with a 25% copayment requirement for hospital services subject to a maximum annual out	Qualifying plans must cover at least the same types of services provided under Medicare but deductible and copayment provisions may vary.	For a prepaid, fixed premium, qualified plans must provide at least catastrophic coverage (initially, threshold would be $2,900 out-of-pocket for an individual or

of pocket family medical expense of 20% of income. Qualifying medical services coverage would include (as defined by Medicare): (1) inpatient hospital services; (2) post-hospital extended care services; (3) home health services; (4) medical and other services; and (5) prescription drugs and biologicals. Extent of maximum coverage is at small employer's option—catastrophic levels not required.

Employers of 50 or more persons required, in any benefit offered, to provide unlimited catastrophic coverage of at least benefits set forth above after out-of-pocket expenses exceed 20% of combined family income annually. Such employers also required to provide coverage for the following preventive health services (to be defined by HHS): (1) comprehensive maternal care; (2) newborn and childhood screening and counseling for heritable and acquired diseases; (3) vision and hearing examinations; (4) childhood immunization; (5) hypertension screening and counseling for adults; (6) screening and counseling for cervical cancer; and (7) periodic health examinations for adults.

All options offered by employers of 200 or more must meet the "employer of 50 or more" standard.

Plan must at least provide payment for 100% of cost of types of services provided under Medicare subject to a $3500 annual out-of-pocket deductible.

If an employer's contribution is not enough to purchase the benefits, it may offer employees one qualifying plan which covers Medicaretype services but with a catastrophic deductible as high as necessary to permit the employer contribution to constitute full payment for the benefits. Any other plan offered would have to meet the full benefit standard set forth in the Act.

family) for medically necessary basic services defined as: medical/surgical and obstetric care; inpatient/outpatient and other institutional health services; home health (aged and disabled) and preventive health services (children); prescription drugs incident to basic health services, blood, emergency transportation, and medical equipment.

Coverage of eye refractions, hearing tests, eyeglasses and hearing aids, mental health services, drug dependency treatment and dental work not relating to injury or disease affecting the jaw would not be required.

Health care contribution amounts and plan premiums would vary according to a subscribing member's actuarial category. Secretary of HHS would establish categories for general population based upon marital status, dependents, sex and age (under 45, 45 or over). Cost of care in individual's health care area would be calculated into health care contribution amounts.

	Sen. Hatch (S. 139)	Sen. Durenberger (S. 433)	Rep. Gephardt (H.R. 850)
Enrollment and "Gap Filling" Requirements	Employers of 50 or more persons must provide coverage without exclusions for preexisting conditions and individuals covered through these benefit plans retain coverage for 6 months (with employer contribution) if employee is terminated or dies. In order to participate in Medicare, Medicaid, CHAMPUS, or any other federally funded health benefits programs, a carrier, by mutual agreement or under State enabling legislation or regulations must enter into **pooling arrangements** in any states where it offers "employers of 50 or more" benefits to make those benefits available to individuals not eligible for a group benefit plan offering them or for a government benefit program. Premium charged such individuals may not exceed 125% of premium of comparable group plans in same area.	All qualifying plans must afford employees opportunity to purchase coverage for spouses and children in addition to themselves. Children who become unqualified for coverage through employee have 180 days to convert without underwriting restrictions to an individual plan providing at least the minimum benefits prescribed the Act. Upon separation from employment, coverage of employee and family remains in effect for 30 days with employers contribution. Continued group coverage available for an additional 180 days at employee's expense with right to convert to a qualifying individual plan during that period. Upon death or divorce of employee, these continuation privileges available to spouse and children.	Qualified plans must offer annual open enrollment on a first-come-first-served basis, except they may apply to Secretary of HHS for approval of a limitation on number of high-risk persons enrolled in order to limit adverse selection. Employers must continue payment to qualified plan for at least 90 days after termination of anyone employed longer than 120 days.
Medicare	A catastrophic benefit would be added to Medicare by eliminating the current 150 day limit on inpatient hospital care and the graduated copayment schedule and substituting a straight annual 20% copayment requirement up to 20% of income from wages or self-employment. Part B benefits would be covered at 100% of UCR subject to same annual 20% copayment requirement.	No changes in Medicare proposed.	Individuals eligible for Medicare could elect to stay under the traditional program or could accept a health care contribution voucher from the government and use it to enroll in a qualified plan. For first 4 years, contribution amounts for Medicare eligible individuals would be based upon trust fund expenditures and would depend on individual's actuarial category (disabled, plus 4 aged categories are prescribed). Individuals electing to enroll in qualified

			plans could not subsequently get back into the traditional Medicare program. When more than 50% of the eligible population had opted out, traditional Medicare program would be repealed.
Medicaid	No changes in Medicaid proposed.	No changes in Medicaid proposed.	Medicaid would continue as is through 1987. Beginning in 1988, a state could irrevocably elect to have those of its residents financially unable to obtain services (as defined in Act) receive a direct health care contribution voucher and enroll in qualified plans of their choice. Plans could not require out-of-pocket contributions for covered services from such individuals. Contributions for these persons would be determined by Secretary of HHS based upon health care areas and actuarial categories and would be indexed according to individual income. States which elect to have Medicaid eligibles receive vouchers would have their Medicaid contribution levels frozen at FY 1981 levels, adjusted for inflation.
Administration	IRS would enforce tax provisions. HHS would issue regulations further defining required preventive services. States would establish and regulate pools, except where they failed to act, carriers could act by mutual agreement.	Insurance carrier or other appropriate private entities would administer the operation of the various health benefit plans. The Secretary of the Treasury would determine if plans qualify under the Acts minimum standards. With respect to determination of "types of services covered under Medicare", Treasury would coordinate with the Department of Health and Human Services.	Health care areas, appropriate health care contribution amounts by actuarial categories, level of state contribution for medically needy, certification of qualified plans, and any limitation of high risk enrollees would be determined by Secretary of HHS. A Federal Health Benefits Assurance Corporation in the Department of Treasury would certify plans financial capacity to fulfill obligations and would administer re-

	Sen. Hatch (S. 139)	Sen. Durenberger (S. 433)	Rep. Gephardt (H.R. 850)
			volving protective fund to assure delivery of benefits to enrollees of bankrupt plans. Fund to be financed by per capita contribution from qualified plans. Act provides for arbitration of enrollee grievances and establishes a U.S. Health Court and Court of Appeals to review arbitrators rulings and handle all other civil actions brought against qualified plans. McCarran-Ferguson Act would not apply to qualified plans, thus making them subject to federal regulation.
Effective Dates	Provisions go into effect on January 1 of the year following date of enactment, except existing plans governed by collectively bargained agreements remain in effect until agreement expires or January 1, 1982, whichever occurs first. Medicare catastrophic becomes effective seven months following enactment.	January 1, 1984	Generally, Act would be applicable to plan years and tax years beginning on or after January 1, 1984. HHS regulations for actuarial categories, determinations of health care contribution amounts, and refund exclusion limitation would be published no later than January 1, 1983. Health care areas and qualification procedures would be published by April 1, 1983. Applications by plans wishing to be qualified for 1984 must be filed with HHS by September 1, 1982. The following would be repealed, effective upon enactment of H.R. 850: **Social Security Act** • PSRO, Part B, Title XI • Uniform Reporting, section 1121

- Capital Expenditure limitation, section 1122
- Hospital Utilization and bylaws, section 1861
- Customary charge limitation, and reasonable cost provisions would be amended consistent with H.R. 850

Public Health Service Act

- HMOs, Title XIII, except section 1308(e)
- Health Planning, Title XV
- Health Resources Development, Title XVI, except sections 1602 (d) and 1622
- After 1984, Hill-Burton requirements for provision of uncompensated care (if 50% of a hospital's patients are enrolled in qualified plans)

The Federal Employee Health Benefits Act would be repealed, effective January 1, 1984.

March 1981

A THIRD PARTY PAYER'S PRESPECTIVE--

MEDICARE VOUCHERS

PROLOGUE

The call from government to the private sector to find ways to solve more of our national problems in the marketplace, rather than depending on government, is encouraging to the Blue Cross and Blue Shield Associations. To the extent a voucher program is a genuine attempt by government to allow our Plans, and insurers generally, to provide good health insurance coverage at a competitive premium to the elderly, it suggests an important increase in responsibility and opportunity for Blue Cross and Blue Shield Plans.

However, this private market "pro-competitive" philosophy is not the only purpose of a Medicare voucher proposal. The difficult fiscal problems government faces may well burden the voucher proposal with the task of making major and immediate cuts in federal expenditures -- cuts that are are greater than than competitive efficiency and innovation can possibly achieve. Just to live within the current Medicare budget, private payers would have to reduce their current costs substantially to make up for the discounts now enjoyed by Medicare with hospitals and physicians. This may be impossible. Whether the voucher system is voluntary or mandatory, vouchers set at unrealistically low levels and limited to future increases at unrealistically low rates would require large additional premiums or extensive new cost-sharing on the part of the elderly population.

These concerns suggest that Blue Cross and Blue Shield Plans address these issues both among ourselves and publicly through mechanisms such as this discussion paper. Such a review will help us to be more constructive in assisting public policymakers in their understanding of how a voucher program might work. It will also help the Blue Cross and Blue Shield Plans in developing their own position on any proposal. Some projects already begun include examination of:

> The cost to a representive selection of Blue Cross and Blue Shield Plans of offering the present Medicare package of benefits as compared to Medicare's own Average Adjusted Per Capita Cost (AAPCC) for offering the same benefits;
>
> All the new costs which would be incurred should the program be privately underwritten; and
>
> The potential of Blue Cross and Blue Shield Plans for reducing the cost of Medicare covered benefits by (1) implementing more effective reimbursement methodologies, and (2) reducing unnecessary utilization of services.

To be most effective, these studies and projects would enlist the expertise and assistance of the individual Plans. The impact of the voucher proposal will vary from place to place because of differences in medical care costs, concentration of the aged population, state regulatory practices, and so forth. Until examples reflecting these variations are studied, neither policymakers nor Blue Cross and Blue Shield Plans will have a full understanding of what would happen under such a proposal.

THIRD PARTY PAYERS PERSPECTIVE--
MEDICARE VOUCHER PROPOSALS

Medicare program expenditures have increased rapidly and virtually without restraint since the program began paying benefits in 1966. Program expenditures will total $40 billion in FY 1981 and are estimated to reach $77 billion by FY 1986. Medicare now accounts for six percent of the federal budget and is the second largest federal program.

The absolute size and rate of increase in the Medicare program makes it a primary target for restructuring in the effort to balance the FY 1983 federal budget. The program will be even more vulnerable during the 1983 budget debates than during the budget exercise just completed by the Congress -- the "easy" cuts in social programs have been made. Adding to the sense that the basic structure of the program needs to be reexamined is the actuarial projection that the Hospital Insurance Trust Fund will be depleted sometime in the early 1990s.

Many also see the restructuring of the Medicare program as an opportunity to test or implement the relatively new ideas of "competition" and "consumer choice". The options for the competition-type changes range from creating more incentives for the elderly to enroll in HMOs to providing the elderly vouchers to purchase traditional private insurance policies.

Changing the entire Medicare program into a voucher program is favored by many as a way to both "cap" the federal commitment under the program and infuse competition into the health care system. The Reagan Administration has established a special task force to develop a voucher proposal and may be introducing a legislative proposal this Fall. Several members of Congress have also expressed interest in such a proposal and have already asked whether Blue Cross and Blue Shield Plans, as traditional insurers, would be willing to underwrite coverage for the Medicare population.

It is clear that the voucher proposals will receive considerable attention in the coming months -- primarily because of the immediate need to realize savings in federal expenditures. Should the Congress or the Administration find the voucher proposals unacceptable, they will consider alternative ways to limit the federal government's commitment under the Medicare program. These alternatives for savings could range from strict caps (indemnity schedules) on hospital reimbursement to major increases in patient cost-sharing based on ability to pay.

This paper examines the voucher proposal, some of the issues arising from such a proposal and the impact of a vouchered program on Blue Cross and Blue Shield Plans as traditional insurers in the fee-for-service sector. Because of heavy involvement in the development and marketing of health maintenance organizations (HMOs), Blue Cross and Blue Shield

Plans will also be interested in the role of HMOs under a voucher program. However, because of the range and complexities of issues, the following discussion focuses primarily on the role of traditional insurers under a voucher program.

What Are The General Assumptions of the "Pro-Competition" Theorists?

The "pro-competition" advocates would present all consumers with a range of choices among health care plans with economic incentives for selecting the least costly coverage. The plans offered would include both traditional insurance plans and alternative delivery systems. In order to make the competition "fair", the contributions made in behalf of the consumer towards purchase of each option would have to be the same.

Competition theorists believe that, under these general circumstances, consumers will purchase protection against health care costs primarily on price considerations -- the premium cost. The competition to offer the lowest premium would, they believe, reduce costs by promoting: (1) higher patient cost-sharing and (2) greater enrollment in alternative delivery systems. They believe that acceptance of greater cost-sharing would lead to a dramatic change in the use and purchase of health care services in the fee-for-service sector. (As noted, this paper does not discuss the role of alternative delivery systems under the competition model.)

- Consumers, because of the higher patient cost-sharing would: (1) question the necessity to use health care services in the first place and (2) shop around for the best prices among hospitals, physicians and other providers.

- Insurers and organized delivery systems would compete to provide services at less cost by: (1) negotiating better payment rates with hospitals and physicians and (2) controlling the utilization of services.

- Providers would operate more efficiently in order to compete for the business of patients and for contracts with insurers.

What Are The Key "Competition" Features of a Medicare Voucher Proposal?

This is how the basic "competition" principals would be applied under the still very general voucher proposals:

- Medicare beneficiaries would select the type of protection they want from an array of options offered by the private market -- including traditional insurance underwritten by the private sector and enrollment in an alternative delivery system;

- The federal government would make an equal contribution in behalf of each beneficiary toward purchase of the plan of choice; and
- Any "savings" from choosing a plan which costs less than the government contribution would be returned to beneficiaries as additional benefits or as a cash rebate.

Since no specific voucher proposal dealing solely with Medicare has developed and introduced, a number of decisions remain as to other characteristics of a proposal. (HR. 850, introduced by Messers. Gephardt and Stockman, does include a Medicare voucher option as part of a larger competition bill which focuses primarily on private market practices.) For example, will use of the voucher be voluntary or mandatory; will insurers be able to charge beneficiaries an out-of-pocket premium (in addition to the voucher amount); will specific benefits be mandated; are insurers to be limited in the amount of patient cost-sharing under their plan; and so forth. Some of the "secondary characteristics" could be addressed in legislation or left to the decision of the open market. Addressing them in legislation might provide necessary protection for beneficiaries, but it would, in many cases, compromise the desire to leave as much as possible to the pure competitive forces of the marketplace.

Is The Voucher Idea Workable?

Any proposal which so radically changes a program relied on by 28 million persons who are over age 65, disabled, or suffer from end stage renal disease, must be approached with thoughtful consideration and examination of relevant experience. The success of the proposal will depend on the behavior of beneficiaries in the selection of their coverage; insurers in deciding whether to participate and their marketing practices; providers in their response to efforts to control cost and utilization; and the federal and state governments in their roles as regulators.

Insurers and alternative delivery systems will be examining the proposal carefully. It may well represent a new market at a time when the only new markets are those that can be "captured" from another carrier. The federal government would represent a stable source of contributions and, ideally, any positive experience gained from the use of vouchers under Medicare would carry over into the private lines of business.

On the other hand, private insurers would have much to lose if, in the near or long term, the voucher proposal did not meet the expectations of the Medicare population or the federal government. For example, to the extent the voucher amount were (or eventually became) inadequate to purchase adequate coverage, frustrated beneficiaries and the general public would most likely turn on insurers rather than the government. These or other frustrations with the program could result in federal and/or state regulation not anticipated under the original legislation and which could be far more extensive and onerous than any regulatory restrictions insurers have encountered to date.

What Are The Key Issues?

1. Can the Government Afford an Adequate Voucher Amount?

Key to the decision of an insurer (or an alternative delivery system) to participate in a voucher system would be their determination of whether the capitation amount is "sufficient".

The yardstick of "sufficient" (either legislatively or through public expectation) would most likely be whether the voucher would purchase the current Medicare benefit package. Indeed, all the general proposals thus far have contemplated mandating the present Medicare level of benefits.

An ideal capitation amount would be one which is fair to the government, the insurer and the beneficiary. It will be difficult to realize this ideal because of the tremendous variation in utilization of health care services among the aged. If the capitation amount is to reflect the average costs of all beneficiaries, the government will be concerned about insurers enrolling a healthier than average population (and being overpaid) and insurers will be concerned about enrolling a sicker than average population (and being underpaid).

In response to these problems, it has been suggested that the capitation amount be adjusted to account for various actuarial factors to the extent feasible. The most often cited method of determining a capitation amount is the "Average Adjusted Per Capita Cost" (the AAPCC), an actuarial concept which is not new to the Medicare program. The AAPCC is the average amount which would be paid by the present Medicare program for services provided to an enrolled beneficiary. The AAPCC can be adjusted actuarially to take into account regional variations in Medicare costs and variation in utilization by age, sex, disability, and institutional status. However, experienced insurers fear that the AAPCC is still too imperfect for widespread use in the program.

Most parties in the voucher debate would argue that, once an initial voucher amount is established, the amount should be indexed in future years to an economic trend factor. To relate the capitation amount to actual program experience would defeat one of the primary objectives of the voucher proposal -- to put an end to the open-ended nature of the program by "capping" it.

There is a widespread feeling among insurers that the capitation amount paid by the government pays would not be sufficient to purchase the Medicare package of benefits for a representative group of beneficiaries without major changes in present marketplace conditions. These concerns arise primarily because of: (a) the index used for yearly ajustments in the federal contribution; (b) the present reimbursement practices of Medicare; and (c) the new costs which might be necessary in a private underwriting scheme. The following is a discussion of these concerns:

Yearly Adjustments In The Voucher Amount -- If the major need of the federal government, in proposing the use of vouchers, is to realize very major and immediate savings, that objective can be achieved only by covering large numbers of beneficiaries under the voucher and by limiting the yearly increase in the voucher amount to something less than the increase in actual expenditures for covered benefits. For example, some have suggested indexing the increase in the voucher to the GNP deflator which increased by 8.9 per cent in 1980 while hospital costs increased by 16.8 per cent.

Under such a limited index, insurers would have to compensate yearly for both the usual inflation in health care costs and a decrease in the real value of the voucher. They could do this in several ways, all of which would eventually be found unacceptable by insurers themselves or the public: charge beneficiaries larger and larger out-of-pocket premiums; pay providers less and less; and market to increasingly healthier groups of beneficiaries.

Medicare Hospital Differential -- Over the years, the Medicare program has tightened the rules used to determine the "reasonable cost" of hospital services. Some have estimated that the Medicare discount for hospital services (the difference between the hospital's charges and what Medicare pays) is as high as 27 per cent. With Medicare such a major purchaser of services, hospitals have little alternative but to accept this differential. It is questionable whether all private insurers could command this differential on their own. If not, they would have to immediately compensate for this differential, probably by increasing the beneficiary's out-of-pocket premium.

Medicare Physician Differential -- According to the most recent data available, Medicare reduced physicians' charges to an amount it recognized as "reasonable" by 18.5 per cent in 1975. Physicians who accept assignment under the program agree to accept the Medicare reasonable charge as payment in full, but only about 50 per cent of all claims are accepted on assignment. The substantial and increasing out-of-pocket payment for physician services is the largest source of complaints among beneficiaries and easily the "weakest" point in the entire Medicare program. While policymakers have examined ways to increase assignment (improved cash flow, payment for administrative costs of accepting assignment), it is generally agreed that the assignment rates will not improve unless the payment rates are increased. The Medicare capitation amount will reflect this discounted physician reimbursement.

Administrative Costs -- The direct administrative costs of the present Medicare program are minimal -- 1.8 per cent of total program payments. This is partly because the federal government, through contracts with private insurance companies and Blue Cross and Blue Shield Plans, performs many of the necessary program functions for beneficiaries, often using the existing social security administrative system. For example, beneficiaries are automatically enrolled in Part A the first time they enter a hospital after age 65; the Part B premium is automatically deducted from the monthly social security check beginning when the beneficiary is first eligible; and beneficiaries are not involved in payment transactions for the majority of covered benefits (e.g., inpatient hospital services).

The administrative costs of insuring 28 million beneficiaries under a variety of different programs is bound to be more than at present. (The administrative costs of private insurance plans which enroll individuals generally runs several times the administrative costs of the Medicare program.) Economies of scale will be lost and many of the functions which are presently "automatic" may have to be performed by insurers, for example, insurers would have to enroll beneficiaries in a plan and may have to collect out-of-pocket premiums directly from beneficiaries. Also, in order to compete, insurers will have to incur marketing and advertising costs. Beneficiaries will also have questions about the various plans: covered services, changing plans, provider choices, the "best buy", etc. One Blue Cross Plan reports that while only 6 per cent of their premium dollars are from their Medigap business, inquiries from Medigap enrollees account for 70 per cent of all walk-in cases and 46 per cent of all phone inquiries. Again, insurers would have to compensate for any new administrative costs.

Catastrophic Limits -- Medicare now covers only 90 days of hospitalization per spell of illness with a 60-day lifetime reserve. There is no limit on the amount of cost-sharing required of patients: a hospital deductible per spell of illness ($260 in 1982); coinsurance for long stays; a $75 deductible under Part B; and 20 per cent coinsurance on all Part B services (except home health). Many of the still very general voucher proposals include a mandated limit on the amount of out-of-pocket payments for benefits, generally about $2,000. The cost of this catastrophic protection is not presently built into the Medicare program and would not be reflected in the AAPCC.

Profit Margin -- Insurers other than Blue Cross and Blue Shield and other non-profit organizations will, as a sound business practice, have to provide for a profit on this line of business.

Build Up Of Reserves -- As a private underwriter of the program, the participating insurers will have to build up a reserve to protect against insolvency. This is not presently a cost which would be reflected in the AAPCC.

2. "Competition" vs. Beneficiary Protection

If one accepts the assumption that the annual increase in the federal contribution would be tied to something less than the increase in actual program expenditures, insurers would have to compensate for an increasingly inadequate voucher amount. Many of the pro-competition theorists are in agreement that the voucher amount will not be sufficient to purchase Medicare benefits given the "present way of doing business." They believe insurers would compete to make the limited dollars go as far as possible by making changes which will reduce total health care expenditures. In the competition to offer the Medicare array of benefits (and additional benefits if possible) for the capitation amount, insurers would, they believe:

(1) negotiate better reimbursement schemes with hospitals; and

(2) control utilization more effectively.

There is, in fact, considerable evidence that Medicare cost reimbursement, particularly in the early years of the program, rewarded hospitals for inefficiencies and encouraged hospitals to add capital and services without closely examining the cost or benefit of the additions. There is also persuasive evidence that the utilization of services among the elderly could be reduced. (Medicare hospital days per 1000 range, by state, from 4441 to 2365.)

Tougher reimbursement negotiations with providers in behalf of beneficiaries today, however, may prove difficult. As mentioned, Medicare is already paying as much as 27 per cent less than private insurers for hospital services. Any efforts by private insurers to further tighten reimbursement could result in hospitals surcharging Medicare patients the difference between what the hospitals perceive as their real costs and the amount they are reimbursed for such patients. (Beneficiaries are protected against this under the present program.)

Introduction of utilization controls tight enough to make a substantial difference in costs is possible, but would probably be "painful". Without good provider-based review programs, retroactive denials (denial after payment has already been made) would result. In the case of retroactive denials, someone pays --the beneficiary, the provider or the insurer. Most likely the beneficiary would be held liable for payment of the bill. However, reducing use of hospital services -- including the length of stay, use of ancillary services, and admissions -- may represent a way to achieve major savings.

A number of other types of market responses to an insufficient voucher payment are also possible, all of which are within the definition of acceptable practices under present state regulatory schemes. However, because of reluctance to turn Medicare beneficiaries over entirely to the "private market" forces, policymakers may find some of these responses unacceptable and either specifically prohibit them in the legislation or establish a mechanism for their regulation. The market responses include the following:

Adjust Benefit Level -- Traditionally, insurers respond to increasing costs by reducing benefits or substituting less costly benefits. It is unlikely, however, that insurers would be able to offer less than the Medicare package of benefits (a very rich package). Policymakers would probably decide that this minimum level of benefits is necessary to protect beneficiaries from purchase of inadequate coverage.

Increase Cost-Sharing -- Increasing deductibles and coinsurance would also have a restraining effect on insurers' payments and is a result generally desired by competition advocates. Many of the elderly and disabled, however, have low incomes and consider even the Medicare present cost-sharing requirements to be prohibitive.

Out-Of-Pocket Premiums -- Insurers can be expected to react to an inadequate voucher payment by charging beneficiaries an additional amount -- a premium -- for enrollment. The existing proposals generally contemplate insurers charging an additional premium, so long as it is the same for all those enrolled in the same plan.

The proposals have not addressed the question of whether insurers must offer a premium which covers only the mandated level of benefits, with additional benefits offered on an optional basis for a separate premium; or whether the insurer can offer only one premium which includes additional benefits such as drugs and vision care. The issue was debated during Congressional consideration of the Medicare HMO bill because of concern that high premiums for "rich" policies could limit accessibility by the low income.

Neither have the proposals addressed the question of regulation of the amount of yearly increases in premiums paid by beneficiaries. If the yearly increases in the voucher amount are to be something less than actual expenditures for covered benefits, the out-of-pocket premium will have to increase rapidly to make up for the decrease in the real value of the voucher payments. Presumably, if the federal legislation is silent on this issue, the states will regulate Medicare premiums in a manner similar to their present regulation of the premiums for Medigap and other nongroup lines of business. Given the political influence of the elderly, states could hold insurers to unreasonably low premiums which require subsidy from other lines of business.

Targeted Marketing -- One way for insurers to compensate for an inadequate voucher amount is a practice which is not new to the marketplace and that is to target sales to healthier groups who will use fewer health care services. Under a voucher proposal which truly embraces marketplace competition, insurers could market to healthier groups by:

Identifying professional groups such as physicians and dentists, and offering coverage through their professional associations;

Attracting healthier beneficiaries through advertising and marketing techniques or by not offering benefits utilized by the very old and chronically ill;

Attracting those with higher incomes who, statistically, are healthier by offering only a very rich package of benefits with a high premium; and

Avoiding adverse selection generally by marketing to groups under circumstances where open enrollment can be avoided or controlled.

These marketing practices might aid the individual insurer, but would not reduce total health care costs. Rather, the effect could be to divide the Medicare population into distinct groups which have very different needs for medical care. This is called "market segmentation" and, at its extreme, can erode the basic insurance principles of spreading the risk among the healthy and the sick alike. For example, those insurers which market to a healthier population could offer low out-of-pocket premiums; the insurers which had more open enrollment and less selective marketing practices would enroll sicker beneficiaries and the out-of-pocket premiums for payment by those groups would be much higher.

As the voucher proposal is refined and modified to protect beneficiaries, some of these traditional marketplace responses may be prohibited or regulated to prevent severe market segmentation. For example, an insurer might be limited to one plan in a geographic area with open enrollment required. The legislation might also provide for a policing of advertising practices. While these requirements may be a necessary attempt to protect beneficiaries, they also compromise the goal of allowing Medicare beneficiaries the same marketplace choices as others and lead to heavier regulatory practices and requirements than are present in the private market.

3. What Are The Assumptions By Pro-Competition Theorists About Beneficiary Behavior?

Key to the success of the voucher proposal is the assumption that beneficiaries will be price sensitive in selecting their health insurance plan from the array of private plans offered. Those who advocate the voucher idea believe that, once beneficiaries are offered a selection of premiums, the incentive to choose a low premium plan would be strong enough that the beneficiary would accept higher coinsurance and deductibles. This higher patient cost-sharing would cause beneficiaries to be more judicious in their use of health care services, thus lowering utilization and costs in general. (As noted, beneficiaries' inclination to select a plan with a lower premium would also, they believe, drive insurers to exercise more cost and utilization control over providers.)

Before so major a change in the program is made based on the assumptions about beneficiary behavior, existing experience with the selection of health care protection by the elderly should be examined carefully. The experience that is available -- largely experience related to the purchase of Medigap insurance -- suggests that beneficiaries make their choice of health insurance protection for a variety of reasons:

> Desire To Budget Expenditures -- Beneficiaries fear unexpected expenses and prefer (now through purchase of Medigap insurance) to purchase first dollar protection.
>
> Health Status -- Beneficiaries who are chronically ill or who are heavy utilizers of medical services may tend to opt for a more comprehensive plan, regardless of premium costs.
>
> Advertising -- The elderly can also be persuaded by advertising that they "need" insurance even though it may be duplicative or inadequate.
>
> Experience With Employee Plans -- Beneficiaries may make their choice on the basis of good experience or a feeling of security with a plan their former employer offered.

The current behavior of millions of beneficiaries suggests that, instead of selecting low premium plans with high patient cost-sharing, they would purchase either first dollar coverage plans (regardless of cost) or purchase additional supplementary insurance to fill the "gaps." At present 65 per cent of the elderly have purchased insurance to supplement Medicare, and 15 per cent have their deductible and coinsurance paid under a state Medicaid program.

4. What Should The Role Of The Federal Government Be?

The Federal Program As An Option -- There will undoubtedly be beneficiaries who would prefer to remain with the Medicare program as presently structured. However, a federal government concerned with reducing Medicare expenditures would have a strong incentive to eliminate the present program as an option for beneficiaries.

The only way for the government to realize major savings is to cover a very large number of beneficiaries under a voucher payment which decreases in value over time. (That is, yearly increases in the voucher would be indexed to something other than actual expenditures for covered services.) Until the present open ended program is eliminated as an option for beneficiaries, it would be difficult (politically) to index yearly increases in the voucher amount only for those who voluntarily used the voucher. And, it is questionable why anyone would opt to use a voucher which is decreasing in value.

Also, until all beneficiaries (or large arbitrarily designated segments of the beneficiary population) are covered under a voucher program, the government might spend more than it would under the program as presently structured. Because of practices of insurers (marketing) or the natural selection processes of beneficiaries, the government is, at the least, likely to encounter to higher costs because of adverse selection. If the better risks were the ones who chose to opt out, the government would be "overpaying" for those who left the program and those remaining would have higher than average costs.

To help counter these potential problems, some have suggested that a phased-in approach be adopted. For example, those already entitled to Medicare benefits would have the option of staying with the program as it is, or of using a voucher to purchase private insurance. Those who first become entitled after the date of enactment would be required to select a plan from the private market. Beneficiaries already on the Medicare rolls would have the option of using the voucher or not. Eventually, the federal program would terminate and all beneficiaries would have to turn to the private market.

Residual Program -- There are a number of reasons for maintaining a "residual" Medicare program. It has been suggested that the disabled under age 65 and the end stage renal disease beneficiaries be kept in the Medicare program. Their medical expenses are considerably higher (by at least twice) than the average Medicare beneficiary. This distinction, however, is unlikely since the Congress has already approved legislation to make private insurance primary for renal patients for 12 months.

The Medicare program might also be retained to provide coverage for those who "fall through the cracks". Some arrangement will have to be made for those beneficiaries who, for some reason cannot make a choice of private plans -- the senile, the institutionalized, the blind, and those who refuse to participate.

There is also the question of what to do about beneficiaries who fail to pay their premiums. This problem is taken care of under the present program by deducting the monthly premium from their monthly social security check. It has been suggested that this practice be continued. Should the premium increase much beyond the current level, however, a substantial number of beneficiaries would probably want the choice of how to spend their cash payment. Private insurers cannot be expected to continue to provide coverage once beneficiaries discontinue premium payments. Some decision would have to be made as to the source of beneficiaries' protection once their private protection ends.

Selection Assistance -- It is unlikely that beneficiaries would have an impartial party to turn to for advice in selecting a health plan. The government might play the role of information counselor by developing, or approving printed information on the various plans. A possible model would be the present regulation of information on Medigap policies (which has been met with varying degrees of acceptance) or the Federal Employees Health Benefits Program.

5. Will The States Or The Federal Government Regulate Insurance?

In addition to resolving the question of what practices will be specifically prohibited by the legislation, policymakers must decide who [illegible] regulate ongoing activities of participating insurers and to what degree. The resolution of these regulatory issues will be key to an insurer's decision to participate.

The practices in question include all those traditionally supervised by the states: legal reserves and surplus; rate regulation; policy form approval (including enrollment practices, exclusions, conversion privileges, renewal rights); and the licensing of companies and agents. Insurers must also be able to "look ahead" to the possible new areas of regulation by states and the federal government as problems develop in the voucher program.

The "Baucus Amendment" of 1980 has already set a precedent for the federal government to intervene in the regulation of private insurance offered to the elderly. That law regulates (albeit, indirectly) individual (and some group) Medicare complementary policies activities related to: sales misrepresentation and sale of duplicative policies; minimum loss ratios; and benefits content and disclosure requirements.

Either at the outset of the program or because of subsequent problems related to uninformed beneficiaries, questionable practices of insurers, etc., the Congress may turn to a regulatory model similar to the present Medigap legislation. Instead of the federal standby program being a mild voluntary certification program, however, it might be made a full scale regulatory scheme with state regulation an alternative only where the state adopts a regulatory program "equal to or better than" the federal program.

What Are The Specific Concerns For Blue Cross and Blue Shield Plans?

The success of the voucher proposal ultimately depends on: (1) whether the voucher amount will be sufficient and (2) whether the accompanying legislative requirements and regulations prove too restrictive.

The voucher amount must either be sufficient to pay for all required benefits (both in the initial and future years) or Blue Cross and Blue Shield Plans must be sure that there are acceptable ways to compensate for any inadequacy. As discussed, the methods of compensation include: charging additional premiums; reducing benefits; increasing beneficiary cost-sharing; negotiating with providers for more efficient (less generous) reimbursement; and controlling utilization.

If the legislation forecloses too many of these options or Plans decide for public policy reasons that they cannot pursue some of the options, (e.g., the cost-sharing becomes too high for the low income beneficiaries), Blue Cross and Blue Shield Plans would have to discontinue participation in the voucher program.

The opportunity to underwrite Medicare benefits represents an opportunity for a new market for Plans. The increasing competition for markets and the increase in self-funding may be a strong incentive for Plans to participate in any vouchering system. The Plans' final decision will rest on the evaluation of the conditions of participation in a vouchering system and whether, in the long run, it will continue to represent a sound business.

Adverse Selection -- Because of name recognition, more open enrollment practices, and more comprehensive coverage, Blue Cross and Blue Shield Plans could attract the higher risks under a voucher program. This "adverse selection" would have particularly disastrous consequences because the voucher would represent the costs of an "average" Medicare beneficiary adjusted only by age, sex, and a limited number of other factors. If this adverse selection were to occur, Blue Cross and Blue Shield Plans would have to pursue the options for compensating for an inadequate voucher more aggressively than other participating insurers: reimbursement negotiation would have to be tougher; additional premiums would have to be higher; and utilization controls tighter.

Plans could also expect adverse selection through the practice of "free riding." This term describes the practice of enrolling in minimal coverage, low cost and switching to a comprehensive plan once a medical condition develops or the expectation of the need for care arises.

Problems With State Approval Of Premium Increases -- There are two regulatory mechanisms for submitting increases for nongroup (individual) policies for approval by the state insurance commissioner. Commercial insurers are generally allowed to use the "file and use" mechanism which allows them to use new rates immediately. Blue Cross and Blue Shield Plans must generally submit a rate change on a "prior approval" basis which means the new rate cannot be used until approved. This often means protracted consideration of new rate request; for example, in some states rate increases for Medigap policies have not been granted in several years or the rate increases approved have not been sufficient to cover underwriting losses.

When this happens, Plans have to subsidize their nongroup lines of business by using up necessary reserves. If the rate of increase in the Medicare voucher amount under the new program were limited, Plans might have to request yearly premium increases which were quite large and which would be resisted, understandably, by the aged groups and the state insurance commissioners (who are generally elected or appointed by the governors). Delay in granting premium increases on such a large volume of business could quickly use up a Plan's reserves necessary to protect all lines of business.

Impact on Private Business Lines -- The payment mechanisms used under a voucher system would presumably be the same as used for our private business. To the extent that experience under the voucher program (or the additional volume it provided) led to more efficient reimbursement negotiations and utilization controls, the private business would benefit. To the extent that greater efficiencies were not enough to compensate for an inadequate voucher amount, private business could be adversely impacted.

Also, in a truly competitive situation, beneficiaries would be free to enroll in any plan they desired including the group plan of former employers. For example, annuitants are currently retained in the experience of the working population under the Federal Employee Health Benefits Program. In this particular case, the adverse risks among the elderly and their generally higher utilization have had adverse impact on the rates of all FEHBP plans. This same phenomenon would be experienced if beneficiaries were successful in remaining in the employee group upon retirement.

Shift In Accountability For Medicare Program -- Under a voucher system, private insurers would become accountable for service, accessibility, affordability, and reimbursement. Beneficiaries would perceive the insurer responsible for rate increases even though insurers were not responsible for a continual "squeezing" of voucher amounts by the federal government.

There is some reason to believe, based on current experience, that Blue Cross and Blue Shield Plans would be more vulnerable to the blame for any resulting problems with the vouchering proposal and more vulnerable to any mandating by the states to resolve the problem, e.g., through assigned risks or open enrollment.

Chairman Jacobs. Thank you.

Your competitors, if I hear them right, have said in essence that all you want is a fair advantage. Do you have any response to that?

Mr. McNerney. With our share of the market I can understand that envy. But what we do, in effect, is negotiate in most sections of the country either what costs we will pay for or what charges or what percentage of them. We insist that if the cash flow we provide is better, our administrative procedures save the hospital money, and if our underwriting practices protect the hospital from adverse risks and bad debts, that these should be quantified and recognized.

I can't think of anybody representing a consumer who wouldn't take that point of view.

Now, parenthetically, and I would be willing to have this challenged publicly, in most sections of the country we pay a larger percentage of the bill even with all of that than our competitors, including our Government competitors.

Chairman Jacobs. Mr. Burton, the committee and the record would probably appreciate if you would challenge that publicly.

Mr. Burton. Well, I might say that we would be delighted to be able to negotiate with hospitals as the Blue Cross organizations are able to do. But, you see they have a 40-percent market share in most States and our largest individual carrier may have 3 or 4 percent, even though collectively the insurance business has perhaps 45 to 50 percent of the market share in each State.

So you really don't have the economic muscle to do much in the way of individual negotiations. Even more important, antitrust laws totally preclude us from attempting to negotiate collectively with hospitals.

We think that is something that you might want to take a look at, to see whether that shouldn't be changed, so that we could negotiate jointly with the Blues or individually for that matter. That could really change the marketplace very dramatically; allowing both large insuring groups to negotiate.

Chairman **Jacobs**. I assume that would not necessarily be for the better. There must be some reason—Teddy Roosevelt must have had something in mind with these antitrust laws. In other words, there is danger to medicine also, isn't there?

Mr. **Burton**. There are clearly dangers and there clearly needs to be oversight. I think we are talking about a very limited antitrust exemption to foster competition rather than to preclude it.

Chairman **Jacobs**. In the absence of Mr. Gephardt I will play the devil's advocate here and ask the panel: Do you believe competition made America great or do you believe Mr. Gephardt's bill isn't really properly defined as competition?

Mr. **McNerney**. What is that last statement? Do you feel what?

Chairman **Jacobs**. I said, do you think competition made America great, or, if you do think that, do you think Mr. Gephardt's bill is not properly characterized as producing competition?

Mr. **Graff**. The label procompetition, I believe implies a certain lack of competition in the marketplace today and I think that is totally false. The magic number used to be for true tailormade group insurance plans you had to have 100 employees. That has been not the case for years and years.

We are now able to write competitive group insurance plans with benefits equal to those of the industrial giants like General Motors, we can write that same identical plan for a group of two.

Chairman **Jacobs**. Do you suppose one of the problems in the health field is the cost-plus nature of reimbursement to hospitals and medicare?

Mr. **McNerney**. I would like to comment on that. But, with respect to your previous question, I think competition and regulation have made America great and that unrestrained competition that doesn't balance the social as well as the economic needs, the political and the public with private needs is unworkable competition and it is a blend we continually have to seek in the design of these bills.

Chairman **Jacobs**. If I weren't the devil's advocate I would probably agree with you.

Mr. **McNerney**. OK. I don't want to play the role of the devil, that is for sure.

Chairman **Jacobs**. Or his advocate either.

Mr. **McNerney**. The second question, I think unrestrained cost reimbursement is bad. There is no question that Blue Cross-Blue Shield during its formative stages, thirties, forties, fifties, probably overshot the market.

During those days people were concerned about enough beds, enough coverage, access. Now we are in a demand economy and it is productivity we are concerned about. I think unquestionably we and everybody else has to move to prospective reimbursement where the provider is put at risk, whether the provider is a doctor or a hospital, the incentives must be shared and not absorbed entirely by the carrier and dissipated through selection and indemnity and weak coverage.

Chairman Jacobs. Well said.

The Congress, the committee and the subcommittee are grateful for your testimony, gentlemen.

Will the next panel please come forward, National Retired Teachers Association, American Association of Retired Persons, Mr. Hacking, and the Gray Panthers and Coalition for a National Health Service, Ms. Klafter; Consumer Coalition for Health, Mr. Sigelman; National Council of Senior Citizens, Mr. Clayman.

Would you just begin.

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL FOR FEDERAL LEGISLATION, NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. Hacking. Thank you. I am Jim Hacking, assistant legislative counsel for the National Retired Teachers Association and American Association of Retired Persons.

These organizations have a combined membership in excess of 13 million persons. I would like to submit the associations' statement for inclusion in the record of this hearing and proceed to summarize.

The associations recognize that there are major structural deficiencies in our present health care [non] system, most particularly in the cost promoting manner in which private and public insurers reimburse hospitals and other providers for the services they render and the products they supply.

There is no question that providers have strong incentives to provide more and more care regardless of the cost.

We also agree that consumers and, especially providers, must have incentives to consider the cost of care. Therefore, we are supportive of the concept that options be provided to encourage increased consumer choice.

However, because of the serious reservations we have as to the manner in which this legislation would ostensibly flame the fires of competition and more assuredly deregulate the health care industry, we cannot endorse any of the competition bills introduced to date.

Overview—health care costs: Health care cost containment is a matter of great concern to our Nation's elderly. The burden of health care cost inflation falls disproportinately upon the elderly, who—while accounting for 11.2 percent of the population—represent 29 percent of our Nation's total health care expenditures. Because medicare covered services do not include such health care expenses as nursing home care, drugs, and dental care, the program is presently covering only 38 percent of the elderly's total health care bill—when beneficiary deductibles, insurance premiums, and cost sharing are considered.

A full 35 percent of the average health bill of an older American now is paid for out-of-pocket.

Voucher proposal: Of primary and direct importance to our associations' membership is the medicare voucher proposal as contained in H.R. 850. Proponents of the voucher proposal see it as a means to contain medicare program costs that are out of control.

Yet Congress has not taken any action addressing the primary source of such cost pressures—rapidly rising hospital costs—increasing at an adjusted annual rate of 19 percent. Because public funds account for over 40 percent of the Nation's health care expenditures, Government holds potent market power and could better exert this power to contain rapidly rising health care costs.

Thus, we question why proponents of the voucher approach seem to be eager to relinguish this market power by spreading it among millions of medicare and/or medicaid beneficiaries.

More specifically, we have serious reservations about a number of provisions contained in H.R. 850's voucher proposal which I will only highlight.

First, we are very concerned about the voucher's key to success being informed consumer choice. While we are pleased that DHHS would be required to develop and distribute a pamphlet—updated annually—describing the competitive health plans for each health care area, the potential pitfalls in this undertaking are numerous.

To explain the terms and conditions of varying qualified health plans in an understandable and readable format that allows for straightforward and simple comparison is likely to be a highly complicated, difficult, and involved task.

Second, the amount of the voucher is a crucial element of the proposal. In our opinion, th amount set will be a key indicator as to whether the voucher proposal is indeed an initiative to inject competition and consumer choice into the marketplace in order to contain costs or will actually result in merely shifting costs from the Federal coffers onto the backs of the elderly benficiaries.

We must have more detailed information on the actual calculation of the voucher amount—particularly regarding the adjustments for age, sex, and regional variation. Health status is also an important variable to be considered in rating.

At the same time, however, we are concerned that use of health status could "inadvertently" serve as a red flag to insurers and become a means for screening out adverse risks.

Third, we would characterize the maximum out-of-pocket or cost-sharing liability—$2,900 per year—that a qualified plan may charge a medicare beneficiary as excessive and somewhat of a mirage for the elderly.

Purchasing health care is most unlike purchasing any other commodity; it is still the physician who makes over 70 percent of all cost decisions.

Understandably, very few patients, especially older patients, feel qualified to challenge the physician's decision—particularly in cases of major, costly illness.

Additionally, stop-loss protection applicable only to acute care services means little to the elderly whose major source of catastrophic health care costs is long-term—nursing home—care.

On the other hand, we are supportive of the concept of placing a ceiling on the exclusion from taxable income of health insurance premiums and tying this to the employee joining—and the employer offering—a qualified health plan.

This approach should provide the employee the economic incentives to consider the cost of each plan option—though this does not translate directly into a more acute or focused attention on the cost performance of service providers nor the broker role physicians play.

There is little to indicate, however, that employees, given the choice—as in the Federal employee health benefits plan—will not select high option, comprehensive coverage even if it means using increasingly scarce aftertax dollars.

It seems workers, like their retired counterparts, desire protection before they become impoverished by catastrophic illness and not afterwards.

We would go further and recommend that an effort be made to combine a cap on special tax treatment of employee health plans with strong cost containment measures to encourage competition among providers who are now insulated from the normal forces of supply and demand by cost-plus, third-party reimbursement.

Therefore, we believe that the proposed limited—but still substantial—preferential tax treatment should be tied to the participation of each employer-employee health plan in a prescribed series of hospital cost containment activities such as adherence to an established ceiling on the rate of increase in reimbursements to hospitals.

Qualifying provider activity could also include such activities as shared services, joint purchasing arrangements, and/or the acceptance by physicians of negotiated fee schedules.

Our associations find the general concept and intent of the proposed competition bills attractive. We have long felt that hospitals and physicians in particular, given their central role in the health care system—and decisionmaking process—must have more meaningful incentives to consider the cost of the care they order or provide.

Most importantly, we do not believe that Congress is faced with an either or choice—competition or regulation.

Change is needed, but certainly the effects of any change made to increase competition in the health care marketplace will take time to be felt.

Therefore, present successful regulatory devices such as local health planning which serve to contain costs should not be stripped away prematurely. Similarly, new regulations addressing escalating hospital costs in particular should not be dismissed without consideration.

Indeed, the challenge is to learn how best to use competition along with necessary government regulation to achieve a much more efficient allocation of health care resources, without abandoning commitments to equity, access, affordability, and quality in the delivery of health care services.

That concludes my statement. Thank you.

[The prepared statement follows:]

STATEMENT OF JAMES M. HACKING, ASSISTANT LEGISLATIVE COUNSEL FOR FEDERAL LEGISLATION, NATIONAL RETIRED TEACHERS ASSOCIATION AND THE AMERICAN ASSOCIATION OF RETIRED PERSONS

INTRODUCTION

Several "pro-competitive" proposals designed to restructure the manner in which health care services are financed and delivered in this country have been introduced in the 97th Congress in an effort to contain rapidly escalating health care costs. These legislative initiatives focusing on enhanced price competition and deregulation include: H.R. 850, National Health Reform Act of 1981 (Rep. Richard Gephardt D-MO); S. 433, Health Incentives Reform Act of 1981 (Senator David Durenberger R-MN); and S. 139, Comprehensive Health Care Reform Act (Senator Orrin Hatch R-UT). It is expected as well that the Administration will present a comprehensive restructuring proposal to Congress late in the year aimed at constraining rapidly rising health care costs through competition in the marketplace.

We agree with the bills' authors that there are major structural deficiencies in our present health care (non) system, most particularly in the cost promoting manner in which private and public insurers reimburse hospitals and other providers for the service they render and the products they supply. There is no question that providers have strong incentives to provide more and more care regardless of the cost. We agree that consumers and, especially providers, must have incentives to consider the cost of care. Providers must be forced to compete on the basis of price, and most importantly physicians, the brokers of services for their largely uninformed patients, must be made more cost conscious. We believe the general approach taken in proposals such as HR 850 of prepayment and prospective reimbursement or budgeting is generically the proper approach. However, we do have some serious reservations as to the manner in which this initiative would ostensibly flame the fires of competition and more assuredly deregulate the health care industry.

OVERVIEW—HEALTH CARE COSTS

Health care cost containment is a matter of great concern to our nation's elderly. Recent surveys of our Associations' membership have clearly indicated that inflation is the number one concern of older Americans. In fact, nearly 80 percent of our volunteer leaders have voiced strong preference for legislation specifically designed to curb inflation over legislation designed to expand benefits to offset the effects of inflation. Within this context perhaps the greatest outpouring of support has been for immediate and effective legislative remedies to deal with rapidly escalating health care costs and to develop some semblance of price competition in the health care marketplace. Given the federal government's role as a massive purchaser of health care services, our Associations feel that efforts toward a more responsible fiscal policy and balanced budget must incorporate strong and effective legislation aimed at this unique sector of our economy. We strongly believe that, without immediate and effective legislative remedies to contain spiraling health care costs, we will be facing proposals for large cuts in our public health insurance programs and needed, meaningful benefits expansion in these programs will be impossible to achieve.

As this subcommittee well knows, the burden of health care cost inflation falls disproportionately upon the elderly, who—while accounting for 11.2 percent of our population—represent 29 percent of our nation's total health care expenditures. Since older Americans in failing health utilize the health care system to a greater extent, the availability, affordability and accessibility of quality health care services is especially important to this segment of our population. While longer life has truly been one of our society's most conspicuous achievements, when combined with declining birth rates this accomplishment inevitably leads to a rapid growth in the number of older Americans and a greatly increased demand upon our health care delivery system. By the year 2025, the portion of our total population over the age of 65 will increase from 11.2 percent (1980) to 17.2 percent (or 50 million people).

Simply stated, we believe that there are two primary obstacles to promoting improvements in the health status of our nation. The first is the belief that all needed levels of care can be supplied through the present medical system. The second is rapidly escalating medical care costs and our country's limited resources. For the elderly, as well as many other of our citizens, those health services that are presently available are often overlapping, confusing, fragmented, and unevenly distributed.

In comparison, the costs of health care are sharply increasing, adding to the general rate of inflation and threatening the stability of government budgets. The nation's health spending is projected to increase from $287 billion in 1980 to approximately $393 billion in 1984—up from 9.4 to 10.2 percent of our Gross National Product (GNP) for these years. In 1980, alone, health care spending jumped from 8.9 percent to 9.4 percent of the U.S. economy's output (GNP), the fastest growth rate in 15 years. Federal health care expenditures (tied as they are to increases in the price of health care services), if unchecked, will also continue to escalate from $62.4 billion in fiscal year 1981 to over $110 billion by fiscal year 1984—or more than 15 cents out of every Federal tax dollar for that year (under current law projections and without hospital cost containment legislation). For individual health care needs, cost will also rise precipitiously. Without strong and effective cost containment measures, the average annual health care costs of a family of four will jump from $2,373 in 1979 to $4,064 in 1984. During the same time period, the cost for a single aged person will rise from $2,259 to $3,868 per year.

The per capita health bill for persons 65 and over was approximately 2½ times that for persons under the age of 65 in 1979. While medicare was designed to pay 80 percent of the elderly's hospital and physician costs, in 1977 it covered only 73 percent of the former and only 55 percent of the latter. The results of this, plus escalating costs for other needed services such as nursing home care, drugs, dental care and eyeglasses (which are uncovered or inadequately covered) are that older Americans are spending more out of pocket for health care today than they did before the inception of medicare and that medicare is presently covering only 38 percent of the elderly's total health care bill (when beneficiary deductibles, insurance premiums and cost-sharing are considered). A full 35 percent of the average health bill of an older American is now paid for out-of-pocket.[1] This figure can be expected to rise based on recent large increases in the Part A and Part B deductibles as passed in the fiscal year 1982 budget reconciliation bill. Only 6 percent of per capita expenditures are covered by private health insurance. Clearly, increasing health care costs and diminishing benefits are constricting the elderly's access to needed health services.

Also, recent CPI figures are equally alarming and instructive—showing an accelerated upward trend in the cost of medical care services. From July to August 1981, the cost of hospital and other medical services rose 2 percent (24 percent annualized and nonadjusted) and medical care services were up 1.3 percent (15.6 percent annualized and nonadjusted). Whatever previous success the Voluntary Effort claimed in holding the line on increasing hospital and physician costs now appears to have evaporated. There is clearly a desperate need to implement cost containing measures in this highly inflationary segment of our economy.

VOUCHER PROPOSALS

Of primary and direct importance to our Associations' membership is the voucher proposal applied to medicare and medicaid as contained in H.R. 850 and being discussed as a "reform" measure by the administration. Under the voucher proposal, medicare and/or medicaid beneficiaries would be given a fixed sum or credit with which to purchase their health insurance in the private insurance market. The purpose of this proposal would be to restrain the inordinate rate of increase in health care costs by injecting some degree of competition into the choice of a health plan and by making the consumer more sensitive to rising costs by asking them to assume a greater portion of such costs out-of-pocket.

The rationale used by members of Congress in support of this so called "procompetition" approach to medicare "reform" revolves around the fact that program costs are out of control ($48.1 billion in fiscal year 1982). Yet Congress has not taken any action addressing the primary source of such cost pressures—rapidly rising hospital costs (increasing at an adjusted annual rate of over 19 percent). Since hospital costs represent over 74 percent of total medicare costs and thus inevitably lead to pressures to cut benefits (most recently through substantial increases in Part A and B deductibles and coinsurance rates) there is a need to legislate limits on the rate of increase in hospital costs while restructuring medicare away from high cost institutional (hospital) services.

Because public funds account for over 40 percent of the nation's health care expenditures, government holds potent market power and could better exert this power to contain rapidly rising health care costs. In this vein, we must question why the proponents of the voucher approach are eager to relinquish this market power by spreading it among millions of medicare and/or medicaid beneficiaries.

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[1] In 1977 older Americans were personally responsible for 98 percent of their total expenditures for eyeglasses, 94.5 percentof their dentists' fees, 86 percent of their drugs, 51 percent of their nursing home costs, plus other professional and health services.

Prepayment and prospective reimbursement

In the long run, voucher or pro-competition approaches to reforming the health care financing and delivery system may be effective to the extent that they institute prepayment and prospective reimbursement or budgeting. The present practice of reasonable cost reimbursement under Medicare and Medicaid is unsatisfactory to government, hospitals, and beneficiaries. For the latter, it drives up program costs and, as such, largely precludes any meaningful improvement in the benefits package. By extension it provides a strong rationale for increased beneficiary cost sharing and benefit cuts in the current fiscal climate. Contrary to the assertion that reasonable cost reimbursement neither fully nor adequately compensates hospitals, we would contend that there are almost no incentives within the present system for hospitals to constrain costs effectively and efficiently manage patient care. The third-party, cost-plus reimbursement methodology for health care services is the most lucrative imaginable. Competition, if it exists at all between hospitals, is for physicians, special services, and equipment and has little if any relationship to prices. Section 223 (1972 Social Security Amendments) limits on rountine inpatient hospital costs have had little impact on high cost ancillary services which remain unchecked by competitive market forces or regulation. It is dangerous to generalize to the effect that "current reimbursement practices do not permit hospitals to generate a surplus of income over expenses in order to finance the replacement and renovation of plant and equipment." Quite to the contrary, our Associations are concerned that, in the near term, absence of local health planning and capital expenditure (Sect. 1122 and certificate-of-need) review along with plans the Congress has for accelerated depreciation allowances there will be a costly explosion in capital spending by hospitals, nursing homes and other institutional providers—as well as a great deal of buying and selling of facilities—all translating into significantly higher Medicare reimbursement in the absence of comprehensive reimbursement reform.

For these and other reasons our Associations can support replacing retroactive "reasonable" cost reimbursement with a system of prospectively determined premiums and Healthcare Contribution such as contained in H.R. 850. We strongly believe that the negotiation of fee schedules, capitation payments and a medical incomes policy of some sort is necessary to reverse our current inefficient system of allocating health care resources. In constructing the proper incentives, it is essential to get physicians to surrender some degree of their independence of action and to construct a reimbursement system which gives them a stake in containing health care costs systemwide.

However, this shift in the reimbursement method will take time. Therefore, in the near term, Congress should move step-by-step to open up to the elderly such options of "choices" as membership in a health maintenance organization (HMO). To the extent that this option is available, it has the potential to greatly reduce hospitalization rates (costs) and insulate the Medicare beneficiary from future cuts in benefits. To this end, the Associations are supportng legislation introduced by Senator Heinz (S. 1509—the CHAMP Act).

Consumer cost-sharing and stop-loss protection

While we understand the need to increase consumers' sensitivity to price, we would characterize the maximum out-of-pocket or cost-sharing liability ($2,900 per year in H.R. 850) that a Qualified Plan may charge a Medicare beneficiary as excessive and somewhat of a mirage for the elderly.[2]

First, we believe that increased patient cost-sharing, while undoubtedly effective in reducing the demand for certain services, could be shortsighted. There is some question as to whether health services foregone would largely take the form of wasteful, excessive and unnecessary care, or needed, preventive-type care. We believe that it is likely that such cost sharing would primarily reduce demand for (and access to) outpatient, Part B (Medicare) type services and that excessive reliance on copayments to reduce demand is obviously shortsighted to the extend that denying (or deferring) significant portions of the population regular access to health maintenance and preventive care leads to more than compensatory increases in other, more costly types of care (e.g. inpatient hospitalization).[3]

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[2] Regarding the excessive nature of this out-of-pocket liability for the elderly we would note that (in 1979) while only 9 percent of the nonelderly-headed households had annual incomes below $5,000 and only 21 percent below $10,000, 31 percent of the elderly found themselves in the former category and a full 62 percent in the latter.

[3] For evidence of the shortsighted effects of excessive reliance on copayments see: Jay Helms, Joseph P. Newhouse and Charles E. Phelps, "Copayments and the Demand for Medical Care: The California Medicaid Experience", *Bell Journal of Economics,* Vol. 9, No. 1 (Spring 1978).

Second, contrary to what some economists who are proponents of pro-competition, consumer incentive plans would have us believe, purchasing health care is most unlike purchasing any other commodity since the consumer is seldom involved in deciding on either the form or the duration of the purchased service. It is still the physician who makes over 70 percent of all cost decisions while the third-party reimbursement system insulates both the patient and the physician from most of the normal supply, demand and cost decisions. Understandably, very few patients, especially older patients, feel qualified to challenge the physician's decision—especially in cases of major, costly illness. In addition, reliance on market forces to distribute health services could further exacerbate the already very serious problem of the maldistribution of physicians and other health care professionals.

Third, such stop-loss protection for those Medicare beneficiaries opting for the voucher proposal means little to this group since it is applicable only to acute core services and ignores the major source of catastrophic health care costs for the aged—long-term (nursing home) care. The lack of a well-designed long-term care system encompassing both health and social services in nursing facilities, the community as well as the home is without question the greatest deficiency in the present health care delivery structure. Plans providing stop-loss or catastrophic protection against inordinate expenditures for Medicare "covered services" only serve to perpetuate this deficiency at the very time that long-term care program costs are being driven up by high rates of inflation, emerging demographic trends and increased utilization of services. We would assert that even for the nonelderly who are afflicted with chronic diseases or conditions, the orientation of their benefits package is ill-advised.

Informed consumer choice

Key to the success of a voucher type proposal is informed consumer choice among competiting qualified Health Plans. In this regard, perhaps the single most significant provision in H.R. 850 relates to the development and conveyance of complete and reliable information on competing Health Plans (and providers). If consumer "cost consciousness" or cost sharing is to be an effective means of developing competition and containing costs, consumers must be active participants in the process. And to be active and involved they must be informed. To date efforts along this line have largely been thwarted by organized medicine hiding behind the cloak of confidentiality and privacy. As a result, health care consumers continue to lack necessary comparative cost, quality, and performance information upon which to base "their" vital health care decisions.

H.R. 850 would require the Secretary of Health and Human Services (HHS) to develop and distribute to eligible persons by October 1 of each year a "pamphlet" for each Healthcare Area on competitive health plans in the area. The pamphlet would have to be in clear, readily understandable language and include information on the terms and conditions of coverage provided by each plan.

While conceptually this approach has much to offer, the potential pitfalls are numerous. Our Associations are all too well aware of the problems involved in providing large numbers of elderly individuals accurate, understandable and timely information on health insurance from our educational and marketing efforts involving "Medigap" insurance coverage—a much narrower undertaking than that envisoned in H.R. 850.[4] Specifying in an understandable and readable format the terms and conditions of each of the Qualified Plans in the Healthcare Area is likely to be a highly complicated, difficult, and involved task. This would especially be the case since the document is to be reviewed and updated annually in each Healthcare Areas.

The amount of the voucher

The amount of the voucher is a crucial element of the proposal. It must be an adequate sum in order to ensure that beneficiaries will be able to obtain private insurance coverage comparable to present Medicare benefits. In our opinion, the amount set also will be a key indicator as to whether the voucher proposal is indeed an initiative to inject competition and consumer choice into the health care marketplace in order to contain costs or will actually result in merely shifting costs from the federal coffers onto the backs of elderly beneficiaries.

As contained in H.R. 850, the amount of the voucher or the Healthcare Contribution would initially be pegged to the average per capita expenditures from the HI (Part A) and SMI (Part B) Trust Funds (less premium payments) for each beneficiary (presently estimated at $1700). Subsequently, it would be the weighted average of the premiums of Qualified Plans (in each Healthcare Area) selected by Medicare beneficiaries during the most recent open enrollment period and indexed to the GNP deflator. The Associations are very concerned about the effects on the voucher amount over time using this method of indexing. As we have stated, medical care costs—particularly hospital costs—repeatedly exceed the general rate of inflation as measured by the GNP deflator or the CPI. Under these circumstances, indexing the voucher to the GNP deflator will reduce substantially the voucher's buying power and most likely, will force the elderly to supplement the voucher with increasingly larger premium payments in order to maintain a static level of coverage over time. To avoid this burden on the elderly, we would recommend that the voucher, if used, be indexed to the medical care component of the CPI.

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[4] Only 6 percent of the average Medicare beneficiary's total health care costs are paid for by private insurance—mostly Medicare supplemental policies.

Benefits package

It is expected that the voucher proposal will create competition among insurance providers that will be reflected in differences in the benefits packages of qualified Health Plans. Importantly, Medicare beneficiaries would be afforded some choice, albeit a much more limited choice than employed individuals. As suggested in H.R. 850, providing the incentive or "sweetener" of additional outpatient drug benefits is very similar to the standards that the HMO demonstration projects being administered by the Health Care Financing Administration (HCFA) must meet.

However, directing the additional benefit of unlimited (inpatient) hospital days beyond the Medicare benefits package would provide very little real benefit for the vast majority of Medicare beneficiaries while in fact being inflationary and cost promoting. It would seem advisable to us to instead provide a cost effective "prevention package" as an add-on, including such services as: health education and counseling; periodic physical exams and health screening; vaccinations; and nutrition counseling.

The Associations also are concerned about the potential problem of "beneficial selection" by insurance providers which could lead to the most vulnerable elderly obtaining the least amount of coverage. We would urge that safeguards against this practice be made explicit in any voucher bill.

In addition, we are unclear on two other points contained in Section 402 of H.R. 850 relative to the Medicare voucher. First, we assume that individuals electing the voucher approach will not be obligated to continue paying monthly Part B premiums. And secondly, that should at least 50 percent of Medicare beneficiaries elect such a course, at that point in time (or the "plan year") the remainder would forfeit any other option. This latter proposal troubles us somewhat since it would regulate a voucher approach for all beneficiaries under such circumstances and restrict competitive insurance options or plans.

The medicaid voucher

The discussion of the reforms contemplated for the Medicaid program are to us deficient to the extent that there does not seem to be a full enough understanding of the impact institutional (nursing home) long-term (LTC) costs are having on State Medicaid programs. It seems to us that one of the major problems state Medicaid programs face in providing hospital services is the fact that they are obligated to follow the cost promoting Medicare reimbursement methodology. Hospitals, especially public hospitals, are incurring large losses from not only treating the full scope of the health care needs of Medicaid eligibles but also a relatively large population of indigents and refugees.

As it is, less than half of all individuals at or below the Federal poverty level can qualify for Medicaid and only 52.5 percent of Medicaid households have incomes at or above the Federal poverty level. In this regard we strongly support the provision in H.R. 850 which would allow States after a four-year period to opt out of the Medicaid system and adopt a single standard of eligibility and a single formula for determining benefits—essentially establishing a national health care program for the poorest and neediest segments of our nation. Exactly how local community health purchasing decisions and regional cost-of-living variations will be accounted for is to us less than clear. We would also note that, while not requiring cost sharing for basic services on the part of low-income individuals is highly advisable, the poor and/or Medicaid eligible individual is generally in much poorer health than the average individual in the same actuarial class in the same community and, as such, in need of a more intensive array of health services. We would also suggest that the "prevention package" we previously discussed could be a highly cost effective supplement to the benefits package that low-income individuals would receive. In effect, it is one way of reducing the above average ($1,300) per capita health care costs Medicaid beneficiaries incur. We must further note, however, that nowhere does H.R. 850 address the severe problems Medicaid beneficiaries face—both now and during the lengthy transition to a competitive market—in getting a provider to treat them. Access to care would remain a problem, especially for chronically ill elderly individuals requiring "heavy care" of long-term duration.

CHANGES IN TAX TREATMENT OF EMPLOYER CONTRIBUTIONS TO HEALTH BENEFITS PLANS

The authors of H.R. 850, S. 433 and S. 139 clearly recognize the role that government plays in fueling the growth in the health care sector by subsidizing the demand side of the equation—largely through the tax laws which encourage first-dollar, broad-based insurance coverage. As you well know, employer and employee paid health insurance premiums are excluded from taxable income. This exclusion or tax subsidy will reduce income tax revenues by approximately $21 billion in fiscal year 1982.

Undoubtedly, employees benefit greatly from the unconditional, unlimited tax-free treatment of employer contributions toward health insurance premiums, thus causing employees to bargain for more comprehensive coverage (with lower cost sharing liability). While not defending this arrangement, though the collective bargaining process is obviously defensible, we would note that employers too benefit greatly from this tax subsidy they receive for their health insurance premium payments. Realistically and practically, employers through collective bargaining arrangements, set limits on this subsidy; also, employers substitute such fringe benefits for (increased) wage demands. It is a mutually convenient arrangement which has led to comprehensive health insurance coverage. In and of itself, this is a desirable goal.

However, given our woefully inadequate and cost promoting reimbursement system such developments at the direct expense of the taxpayer have led inexorably to excessive increases in health care costs. Too often rapidly accelerating Medicare and Medicaid program costs are looked at in isolation without examining the real reasons for such trends nor the substantial tax subsidy the non-aged, working population enjoy in receiving health care services. Additionally, excluding health insurance premiums from taxable income in an unlimited fashion further compounds the short term Social Security financing problem since in fiscal year 1982 some $7 billion in Social Security payroll taxes will be lost as a result of this particular feature of the tax code.

Due to the continued rapid escalation of health care costs, the consumer's consciousness is being raised regarding price. The consumer needs to be given a greater degree of discretion in his/her purchase decision. Therefore, we are supportive of the concept it all three bills of placing a ceiling on the exclusion from taxable income of health insurance premiums and tieing this to the employee joining (and the employer offering) a Qualified Health Plan. While the bills differ somewhat in details (i.e., limit on the amount that can be excluded from taxable income and amount and tax-status of rebate to employees who select less costly health plans), this approach seems logical and reasonable and should provide the employee the economic incentives to consider the cost of each plan option—though this does not translate directly into a more acute or focused attention on the (cost) performance of service providers, the broker role physicians play, nor the need to restructure the Medicare benefits package and spending patterns away from high cost hospital care.

While the current bias toward employees selecting more insurance in place of higher wages may be gradually eliminated, "economically rational decisions" as to the amount and type of insurance employers will finance and employees select may not result. There is little to indicate that employees, given the choice (as in the Federal Employee Health Benefits Plan), will not select high-option, comprehensive coverage even if it means using increasingly scarce after-tax dollars. It seems workers, like their retired counterparts, desire protection before they become impoverished by catastrophic illness and not afterwards. This may, in fact, represent the biggest problem with the consumer choice, competition model. For it to be a viable alternative to a more regulatory-intensive approach, a signficant shift in national attitudes towards health insurance will be required.

Because this shift in attitude will take time and because our Associations do not view regulation "a priori" as a bad approach to the problem of rising health care costs, we would recommend that an effort be made to combine a cap on special tax treatment of employee health plans with strong cost containment measures to encourage competition. Since the health care industry is insulated from the normal forces of supply and demand by cost-plus, third-party reimbursement and government subsidies of supply and demand, regulation can and should be relied upon to alter the incentives driving providers and to curb their voracious appetite for an even greater share of our nation's increasingly limited resources. The goal of such regulation should be system or structural change and not merely price fixing. Therefore, we believe that the remaining preferential tax treatment (which would still be substantial) should be tied to the participation of each employer-employee health plan in a prescribed series of hospital cost containment activities—including adherence to an established ceiling on the rate of increase in reimbursements to hospitals. To achieve this, the availability of this substantial tax subsidy should be contingent upon a private group plan's contractual participation in a State hospital rate review program. In this regard, I would note that recent data indicate that Washington State's prospective reimbursement program, which encompasses all patient revenue (i.e. Medicare, Medicaid, Blue Cross, etc.) has reduced per capita hospital expenditures 3.1 percent below what they would have been in the absence of such a program. Qualifying provider activity could also include such activities as shared services, joint purchasing arrangements, and/or the acceptance by physicians of negotiated fee schedules.

Similarly, we would support minimum federal standards requiring a multiple choice of health plans including an HMO option when it is available. Only by encouraging the development of alternative delivery systems such as HMO's can we begin to implement necessary system and structural changes in our health care system. Indeed, while the 1973 Health Maintenance Organization Act officially marked the beginning of a favorable turn in federal policy toward the development of HMO's, many observers believe this legislation was drawn much too narrowly and may in fact represent the chief barrier to HMO development. Evidence of this is seen in the very high minimum standards of comprehensiveness of insured services, which in some cases exceed those typically contained in private health insurance policies. At best, current policy seems to offer HMO's as an occasional alternative to a dominant system.

Finally, H.R. 850 effectively deregulates the health care industry. Like the author, we would prefer a free and open environment where market forces effectively and efficiently allocate increasingly scarce health care resources. However, realistically, the blanket elimination of such successful regulatory activities as local health planning, State hospital rate review programs, and Professional Standards Review Organizations (PSRO's)—in the absence of major structural changes in the delivery of services and changes in provider attitude—would be cost promoting. For example, indications are that the product of eliminating or "phasing out" federal support for local health planning (in combination with the adoption of accelerated depreciation allowances for capital expenditures) will be a 50 percent (or $10 billion) increase in hospital capital expenditures over the next five years. Such allocations are not likely to be based upon need or even the willingness (however expressed) of Plan members to pay increased premiums for new facilities, equipment and service but rather on the financial rating of the hospital or provider. Such successful regulatory systems must be retained and in fact solidified in the lengthy transition to a more rational, competitive and by extension cost constraining system of financing and delivering health care services. While we strongly support the removal of regulatory barriers which restrict the entrance into the marketplace of truly new and innovative providers (and strict as well as equal enforcement of our antitrust laws in this market), this should not be undertaken until and unless established providers are no longer insulated from the competitive pressures of the marketplace via our cost promoting reimbursement system.

SUMMARY

Our Associations find the general concept and intent of the proposed competition bills attractive. We have long felt that hospitals and physicians in particular, given their central role in the health care system (and decisionmaking process), must have more meaningful incentives to consider the cost of the care they order or provide. The reimbursement system we presently employ must be radically reformed so all parties will no longer be insulated from the effects of competition. Unfortunately, we view the total deregulation of the health care industry in the absence of lengthly transition periods as detrimental to the interests of health care consumers in general and the elderly in particular. Such action in a predeterminative and highly nonselective fashion presupposes a willingness on the part of organized medicine and physicians generally to give up some of their independence of action and certain regulatory protections (e.g. State "scope of practice" laws). Consumer responsibility and even new found knowledge cannot create a new dynamic, competitive marketplace. Without active physician support new and innovative service delivery systems will not develop magically overnight. And even if they did, for the elderly, the fraudulent and abusive business practices they encounter in purchasing limited "Medigap" policies are likely to be multiplied many times over—at least initially. Simply stated, physicians and many other providers have a vested interest in the status quo. Complaints about the inadequacies of Medicare or even Medicaid reimbursement do not seem to have been translated into support for bold new departures.

The traditional catastrophic-competition proposals have emphasized cost containment through increased patient cost-sharing liability. Much like H.R. 850 and others, they also rely excessively on consumers to force price-and-quality-competitive behavior out of health care providers. However, the implicit and misplaced faith of these proposals in the market power of consumers has unfortunately led to a dearth of suggestions as to explicit measures policymakers might take to enforce competitive behavior on the part of service providers. While we do subscribe to the theoretical efficacy of competition among closed panel health plans for insured members and competition among providers for alliances with particular plans, we strongly believe that the operative factor will be the physician's disposition to go along with much more prescribed behavior (practice) patterns.

In the final analysis, the key to movement along the path outlined in H.R. 850 is assuring the elderly (and/or their agents) that they will have complete, reliable and timely information on health plans and providers. But even this, unfortunately, will not quickly reorient the elderly away from excessive reliance on the non-medical services of the physician-broker. Much like some government regulation, organized medicine seems intent upon "freezing initiative and discouraging innovation." This is the problem public policy must address if our health care (non) system is to be effectively restructured and reformed along more rational lines.

Indeed the challenge is to learn how best to use competition along with necessary government regulation to achieve a much more efficient allocation of our health care resources, without abandoning commitments to equity, access, affordability and quality in the delivery of health services.

STATEMENT OF FRANCES KLAFTER, ON BEHALF OF THE NATIONAL HEALTH TASK FORCE OF THE GRAY PANTHERS, AND COALITION FOR A NATIONAL HEALTH SERVICE

Ms. **Klafter**. I am Frances Klafter, and I am speaking for the National Health Task Force of the Gray Panthers and for the Coalition for a National Health Service.

A major concern of the Gray Panthers, since their inception, has been accessibility of quality health care to the people of this country. For that reason we have been active members of the Coalition for a National Health Service, for whom I am also speaking today.

We are particularly concerned about the effect of the proposed bills to stimulate competition in health care on the accessibility of health care to the elderly and disabled and to low-income workers and nonworkers.

We believe that it is to the economic as well as the moral interest of the Nation to keep its people healthy. As a civilized nation, it seems to us, we must recognize accessibility to health care as a basic right.

We, therefore, cannot support proposals such as these, that have as their barely disguised purpose the limiting of the accessibility of health care for those unable to pay high insurance premiums, copayments and deductibles.

Because the elderly, with their special health care needs, are particularly vulnerable, I would like first to discuss briefly the effect of the proposal to offer vouchers to medicare beneficiaries to purchase their own health insurance.

Because we know of the abuses elderly people have been subjected to in the sale of so-called Medigap insurance, we are horrified at the prospect. If you are not familiar with this dismal history, I respectfully refer you to the hearings of the House Select Committee on Aging on this subject.

Medicare, contrary to the beliefs of the general public, has certainly not covered a major part of the health care costs of the elderly, and the Gray Panthers have been very concerned about the wide gap between expectations and actuality. But we would prefer to continue to join with other interested groups to try to make medicare more responsive to the health needs of the elderly and the disabled than to have to junk it in favor of the proposed voucher system.

One approach we have taken to cost containment under medicare has been to launch a nationwide effort to stimulate medicare beneficiaries to persuade their doctors to accept medicare assignment, that is, to charge only the medicare approved "reasonable charges," rather than more than that amount, as many of them now do.

For this purpose, we have been urging Gray Panthers and other organizations to secure from the medicare insurers under the Freedom of Information Act lists of doctors and other providers under medicare Part B who have served medicare patients, indicating whether they do or do not accept medicare assignment.

The Public Citizen Health Research Group, with our full support, has gone further and urged the Department of Health and Human Services to require the insurers to compile such information and make it available to consumers on request, so that they would not have to go through hassles to get information which would permit medicare beneficiaries to select their doctors on a competitive basis.

So you see, we, too, believe that consumers should be cost-conscious in selecting their health care providers, and that providers should have to compete for patients not only on a quality of care but on a cost basis.

I should also mention briefly the problem of long-term care. Under a combination medicare-medicaid package, it has been possible for many people whose resources have been exhausted by illness to obtain nursing home care, when needed.

It is not clear what would happen to people needing nursing home care under a medicare and medicaid voucher system. Certainly, the cost of an insurance policy covering long-term care is prohibitive to most elderly and low-income people.

The Gray Panthers and the Coalition for a National Health Service despair of any proposals that would further attempt to patch up a sick so-called health care system, which, in fact, is geared not to keeping people healthy, but to treating the sick and dying.

We believe in a health care system that would stress health prevention services, and would not discourage people from seeking needed care until their illnesses reach a disabling, outrageously expensive stage.

We are convinced that quality health care will be available to the people only when the profit is taken out of health care and health services are not sold as commodities, but made available to people in community-controlled health centers. That is why we support, even though at this point it seems a hopeless dream, H.R. 3884, the Dellums bill, providing for the establishment of a National Health Service.

I thank you for the opportunity to participate in these hearings.

Chairman JACOBS. Thank you, ma'am.

STATEMENT OF DANIEL W. SIGELMAN, COUNSEL, ON BEHALF OF THE CONSUMER COALITION FOR HEALTH

Mr. SIGELMAN. I am Daniel Sigelman, speaking on behalf of the Consumer Coalition for Health. We have submitted for the record a piece entitled "The Competitive Prescription for Health Care: Survival of the Fittest?" which summarizes many of the reasons why we feel that the competition strategy as embodied in many pieces of proposed legislation cannot work.

Today I would like to focus my attention on two major areas of our concern about the competition strategy. One, the potential impact of the competition strategy on the poor and, two, the potential effect of the competition strategy on the elderly.

We feel, first of all, that the bills promise very little in the way of providing proper incentives for insurance plans to enroll the poor. For example, in setting actuarial categories for voucher amounts Gephardt-Stockman does not take into account the impact of income on health status; yet study after study have demonstrated that income is integrally related to health status; that is, low-income people tend to be sicker and have greater health needs.

Consequently, the poor cost more to treat. Unfortunately, Gephardt-Stockman does not promise greater premium subsidies for plans which take the poor.

Also, the bill proposes to cap premium vouchers using the GNP deflator, a measure which would understate the rate of hospital inflation by a factor of two. So what we will find with the adoption of this proposal would be weak incentives for insurance plans to enroll the poor—the high-risk people who need health care the most.

Moreover, one of the major objectives of the competition strategy is to eliminate what are deemed to be inefficient cross-subsidies; that is, where hospitals use excessive charges to private patients in order to subsidize the reimbursement shortfalls from medicaid and medicare for care given the poor and the elderly as well as to subsidize the uncompensated care delivered to uninsured patients.

It is all well and good to try to get hospitals to compete on the basis of price and to end what is deemed to be inefficient cross-subsidies. But unless proponents of the competition strategy are willing to subsidize these shortfalls through transfer payments to institutions willing to serve the poor or are willing to include the absence of these cross-subsidies in the vouchers they offer the indigent, then the poor are going to suffer.

Unfortunately, a bill like Gephardt-Stockman does not take into account the adverse impact on the poor resulting from the elimination of these cross-subsidies.

Once someone gets enrolled in a plan he or she has to find a provider to treat him or her. The competition strategy would provide very weak incentives for plans determined to minimize their treatment costs to include among their list of participating providers institutions and physicians willing to serve and located near high-risk populations.

We would have a very serious problem in terms of ensuring accessible providers for the poor. Here I wish to highlight the problem that the public hospitals have been facing in the United States. In many cases, these institutions are the only ones willing to serve the high-risk poor. How would public hospitals with the high-risk cases fare under competition? We don't think they would fare at all well so long as the central incentive—the driving force within the system—would be to minimize treatment costs.

Once the poor find plan reimbursable providers, they need to get quality treatment. Here we would like to call attention to the greatest "competitive" experiment ever conducted concerning the poor—the California medicaid prepaid health plan program where in the early seventies scandal after scandal was revealed after massive enrollment fraud was encountered. Plans simply went into the market and provided substandard and in many cases no services to MediCal beneficiaries.

Much of what I have said applies with equal, if not greater, force to the high-risk elderly. As has been mentioned earlier today, the administration's medicare voucher proposal, at least as summarized in the Washington Post and the Gephardt-Stockman bill would probably cap the rate of increase in vouchers for the elderly beneficiaries at rates much below the rate of medical care inflation; again the GNP deflator has been prominently mentioned as an inflation cap.

We think this could generate competition, but it may not be competition over the delivery of more cost effective medical care but rather competition over enrolling healthier, younger and more affluent beneficiaries who demand less costly care and can better pay their own way than many financially pressed, chronically ill elderly.

We certainly do have some evidence that when elderly beneficiaries are enrolled in competitive systems that favorable selection often occurs. Three out of four of the medicare HMO demonstration projects that HCFA has looked into so far have shown favorable selection. Medicare HMO's often seem to enroll beneficiaries who tend to be the lowest users.

The folly of giving elderly people vouchers is demonstrated by the scandals that were revealed—as Frances Klafter mentioned—in the medigap industry.

The medigap industry represents a much smaller insurance market in which elderly beneficiaries were subject to fraud and abuse in terms of marketing practices; in addition, they have had tremendous problems trying to make sense of competing plan options and benefit packages.

The medigap problem underscores the kinds of problems that this theoretical concept of medicare vouchers would in fact encounter if translated into practice.

Moreover, many people believe that we don't really have to worry about medicare voucher programs because we will retain the residual medicare program.

The Consumer Coalition for Health, however, fears that a medicare voucher program would become a competitive prelude to eventual phaseout of the medicare program or at the very best massive reductions in that program such that even the medicare program is no longer at a tremendous competitive advantage to the medicare voucher program.

Certainly indications that we are in store for massive cuts in medicare benefits have come with the recent cuts in the Omnibus

Budget Reconciliation Act which have substantially increased the out-of-pocket cost burdens of medicare beneficiaries.

Thank you very much, Mr. Chairman.

[The article referred to follows:]

The Competitive Prescription for Health Care: Survival of the Fittest?

Daniel W. Sigelman*

The invisible hand of the marketplace may soon be transplanted onto the healing hand of medicine. Mounting disaffection with the failure of government regulation to control soaring health care costs has led many to reconsider what they once regarded as a virtually unassailable truth—namely, that conventional competitive market forces could play no role in controlling the economic behavior of the medical care industry.

The conviction that competition could better discipline the medical marketplace than regulation has given birth to an important legislative strategy—the so-called "competition" or "pro-competition" strategy. This strategy first gained public attention when Stanford Professor Alain Enthoven, in September 1977, offered his Consumer Choice Health Plan[1] as a competitive alternative to the highly regulatory national health insurance proposals then being presented.

After Congress overwhelmingly defeated President Carter's regulatory hospital cost-containment legislation in late 1979, and with the recent Reagan landslide and the resulting realignments in Congress and the executive branch, this strategy has moved from the ideological background to the political center stage. Faith in the effectiveness of competition to control escalating health care costs, in fact, underlies President Reagan's recommendations for federal deregulation of the health care industry.[2]

During the last Congress (1979-1980), six competition bills were introduced, three of which have already been reintroduced in 1981.[3] Serious Congressional consideration of these proposals in the near future seems certain, particularly since most of those who have sponsored competition legislation in the past have recently ascended to positions of great power and influence. Former Representative David Stockman has become Reagan's domestic policy czar as Director of the Office of Management and Budget. Recently retired from the Senate, Richard Schweiker now heads the Department of Health and Human Services. Orrin Hatch now chairs the Senate Labor and Human Resources Committee. David Durenberger has been made Chairman of the important Senate Finance Health Subcommittee. Congressman James Jones, one of the Democratic competition advocates, has assumed the reins of the powerful House Budget Committee.

This article will assess the effects of the competition strategy on those who currently have health insurance coverage, especially those with group employment insurance.[4] It will raise questions about the workability and fairness of any of the competition proposals for the millions who currently have adequate health insurance protection.

The impact of the competition legislation on the uninsured and underinsured poor and working poor will also be explored. Some of the proposals contain provisions designed to provide access to mainstream medical care for the traditionally underserved. The Gephardt-Stockman bill, for example, claims to provide substantially expanded access for low-income individuals by means of vouchers which the poor could apply to the premium of any competing insurance plan. Serious doubts will be raised whether the proposals suggested by the competition strategists will ever offer insurers and providers sufficient incentives to enroll large numbers of low-income consumers and provide them with high-quality care.

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*Daniel W. Sigelman is a staff attorney at the Public Citizen Health Research Group, 2000 P Street, NW, Washington, DC 20036 - (202) 872-0320.

BASIC ELEMENTS OF THE COMPETITION STRATEGY

Despite vast differences in their scope and design, the competition bills share three common objectives as part of their goal of letting the marketplace lower medical care costs: (1) creating tax incentives for employees to shop around for more cost-effective insurance plans; (2) providing catastrophic health insurance protection; and (3) fostering vigorously competing organized delivery systems.

Altering Tax Incentives

Competition advocates maintain that federal tax treatment of employer-paid health insurance—the predominant source of private health insurance coverage[5]—fans the flames of health care inflation. Since the contributions employers make to their employees' group health insurance plans are currently not considered taxable employee income,[6] employees have no immediate incentive to elect less-expensive, lower-option plans. The more insurance that employees have, competition proponents believe, the more insensitive they and their families are to the cost of the services they demand and receive. Only if consumers have lower-option plans requiring more cost sharing will they begin to weigh the costs of care before they seek it. To effect this change in consumer buying behavior, the competition bills generally put a cap on the amount of employer-paid health insurance that is not considered taxable employee income.[7] Employees wanting coverage which costs more than this ceiling must include the employer-paid excess over the limit as taxable income. Conversely, if they select policies costing less than the ceiling, they are entitled to a rebate, the form and tax status of which vary among the bills. Competition strategists believe that this simple modification in the tax laws will prompt many consumers to begin shopping around for and ultimately buying less costly, more cost-effective health insurance. Some of the bills, in fact, specifically require employers to offer their workers at least one low-option plan.[8]

Providing Catastrophic Health Insurance Protection

A system which successfully induces employees to buy substantially less health insurance protection runs the obvious risk of subjecting many workers and their families to major uncovered medical expenses that may well be beyond their financial means. Recognizing this, all of the bills incorporate the catastrophic health insurance concept. Employees and their families are guaranteed full insurance protection beyond a maximum out-of-pocket expenditure or percentage of annual income ceiling.[9] To varying degrees, some of the bills extend the catastrophic insurance umbrella to individuals not in employee groups.

Fostering Competing Organized Delivery Systems

As consumers become more concerned with the comparative costs of various insurance plans, competition theorists expect far more vigorous price competition among these plans. A central premise of the pro-competition belief is that insurers will ultimately be forced to respond to their new competitive environment by pressuring providers to deliver more cost-effective medical care. The doctrine, in short, assumes a "domino" effect—price-sensitive consumers apply competitive pressure to insurers who in turn apply such pressures to providers. Ultimately, providers will have no recourse but to compete spiritedly for the business of one or more insurance plans by making their services available at the lowest cost.

In this scenario, more and more providers would be expected to deliver care to defined sets of enrollees, largely for a prospective capitation payment. Pointing to the competitive experience of alternative delivery systems such as HMOs, market advocates predict a transformation from fee-for-service and cost-based reimbursement financing to a system dominated by prepaid capitation payments. As Enthoven envisions it, providers would form into "competing economic units"[10] as insurance plans would increasingly seek to deal only with those providers who had proven themselves cost effective.[11] Insurance premiums would thus accurately reflect plans' comparative ability to control costs.

THE COMPETITIVE STRATEGY MAY NOT PROVE VERY COMPETITIVE

Providers May Continue to Elude Cost Controls

The domino theory's assumption that greater inter-plan competition would ultimately force providers to cluster into vigorously competing economic units could prove rather naive. Powerful provider groups have shown no inclination to trade the certain bonanza of fee-for-service medicine[12] and cost-based reimbursement[13] for such a largely untried venture. "Some of those who are now so eager to end... regulation," Harvard health economist Marc Roberts believes, "cannot be counted on to support real pro-competitive changes in financing when the time comes."[14] In fact, the relatively few sellers in medical care delivery markets are generally protected from competition by consumers' low willingness to travel and the difficulties facing those wishing to enter such markets. The sellers, Roberts writes, may never have to "behave in a highly rivalrous manner." Through an "anticompetitive accommodation" they could "tacitly cooperate to raise prices for their mutual advantage."[15]

Ardent competition advocates, among them Gephardt and Stockman, want to preserve the fee-for-service alternative for those who are willing to pay more to have a free choice of doctors.[16]

SO LONG AS FEE-FOR-SERVICE MEDICINE IS AVAILABLE, REAL COMPETITIVE PROVIDER MARKET BEHAVIOR IS NOT LIKELY TO OCCUR.

Yet, so long as fee-for-service medicine is available—and likely to attract large numbers of consumers—real competitive market behavior is not likely to occur. The fee-for-service sector may raise its prices and provide more questionably necessary services in order to make up for its lost share of the market. This may force prepaid group practice plans to offer their physicians more pay and their members more convenience and accessibility. As a result, such plans' costs may then float up along with those of fee-for-service providers.[17] Evidence that competing prepaid group practice plans have "not aggressively constrain[ed] the growths in costs over time" is provided by the Federal Employees Health Benefits plan where, over a ten-year period, HMO premiums consistently hovered just $5 to $10 per month below the Blue Cross/Blue Shield rates.[18]

Insurers May Insulate Providers from Competitive Market Pressures

The domino theory assumes that insurers will act as agents of newly cost-conscious consumers in imposing cost controls on providers, despite the traditionally cozy relationship between the insurance industry and providers[19] as well as the nature of the provider-dominated medical care delivery marketplace.[20] Walter J. McNerney, President of the Blue Cross/Blue Shield Association, has stated that insurers can adopt several measures short of negotiating lower reimbursement rates and increasing provider efficiency—among them experience rating and preferred risk selection—to avoid confronting and thereby alienating providers.[21]

Inadequate Consumer Information Precludes a Truly Competitive Market

The classic market model assumes that producers of goods and services compete for consumers on the basis of price and quality. The domino model of health care financing, however, perpetuates the current insulation of consumers from the behavior of medical producers by interposing insurance companies between them. Under the competition proposals, consumers shop around for health insurance rather than for providers having certain characteristics and medical track records. Only when consumers know more about the performance of competing providers will there be a genuinely competitive marketplace.

Even under our present system, where the comprehensively insured patient has little, if any, incentive to shop around for cost-effective care, competition could be fostered simply by disclosure of comparative quality-of-care information. Patients do want the best possible care available to them. For example, consumers in Washington, D.C., responded to a report on cardiac surgery by cancelling scheduled heart surgery at unfavorably reviewed hospitals.[22]

Consumers need to know how the utilization patterns—lengths of stay, surgery rates, diagnosis- and procedure-specific admission rates—compare among the doctors and hospitals serving each competing plan. Disclosure of data such as that collected by Professional Standards Review Organizations (PSROs) on mortality and complication rates for individual providers could be vital for stimulating competition among them. Yet, competition strategists do not encourage, and even oppose, public disclosure of comparative provider practice patterns that would allow consumers to choose among plans on the objectively verifiable quality of their providers.[23] But, according to Roberts, unless competition proponents aggressively "support the release of doctor-specific data on surgery complication rates or...lists of physicians whom PSROs find to be over-utilizing... consumer confusion will blunt the extent to which the market disciplines competitors for poor performance with regard to either quality or price."[24]

WHY THE COMPETITION STRATEGY MAY NOT WORK

Competitive Alternative Delivery Systems Have Yet to Prove Themselves

Enthoven, like other competitive market proponents, believes that the non-competitive cycle in medical care delivery "can be broken if two or more organized systems were competing against each other as well as against the fee-for-service sector."[25] Competition advocates invariably point to areas of high HMO penetration—especially Minneapolis, California, and Hawaii—as examples of a highly competitive system in action. However, health economist Harold Luft, who acknowledges that HMOs have significantly reduced hospital utilization, has found no evidence that they have been responsible for actually lowering community-wide, per-capita health care costs, the ultimate measure of cost-effectiveness.[26]

Employees May Retain Their Appetite for Comprehensive Coverage

One feature distinguishes the purchase of insurance from that of many other goods and services—risk-aversion. Whether workers would forgo some health insurance protection for themselves and their families in order to obtain a rebate or avoid higher taxes depends on how averse they are to the unpredictable risk of very expensive illness or injury. If the experience of members of the Federal Employees Health Benefits plan[27]—the prototype of consumer choice to which Enthoven and other competition proponents look—is any indication, employees generally prefer incurring a known expense to surrendering comprehensive coverage. In 1979, only 11.6% of all federal employees chose low-option plans.[28]

EMPLOYEES GENERALLY PREFER INCURRING A KNOWN EXPENSE TO SURRENDERING COMPREHENSIVE COVERAGE.

Even sponsors of competition legislation do not always appear confident that employee insurance purchasing habits can be changed substantially. Congressman James Jones, for example, has stated that the costs of implementing the catastrophic features of his proposal would be more than offset by the additional taxes paid by those employees who choose a plan with a premium above the tax-free limit.[29] Buried in his reassurances about the fiscal soundness of his catastrophic plan is an admission that large numbers of employees would continue to opt for comprehensive health care coverage.

Employees May Fluctuate Between High- and Low-Option Plans

Even if a large share of the work force generally would choose low-option insurance coverage under a competitive system, program success will be seriously compromised if employees switch between high- and low-option plans depending on their perceived medical needs. A Blue Cross/Blue Shield study of the federal employees' plan found that during the 1975-76 open season, new individual high-option plan enrollees used services 45% more than other high-option individual insureds, and new family high-option enrollees used services 55% more than other family high-option subscribers. At the same time, of those who dropped high-option coverage, individuals registered a 55% lower utilization rate and families a 65% lower utilization rate than all others enrolled in the same categories.[30] If employees switch coverage depending on anticipated medical need, the ability of a competitive system to control utilization could be severely limited.

REGULATING IN THE NAME OF DE-REGULATION

The competition strategy is often touted as an alternative to regulation of the health care industry. The Gephardt-Stockman bill, for example, flatly states: "Competition among qualified plans will be based on market incentives and disciplines, thus permitting natural economic forces to work and making regulation unnecessary."[31] This bill not only predicts de-regulation, but like many of OMB Director Stockman's budget recommendations, promotes it by calling for repeal of major regulatory programs like health planning and PSROs.

Beneath this surface hostility to regulation, however, lies a system which creates and depends on perhaps even more regulation than exists at present.

> THE HEALTH INSURANCE INDUSTRY UNDER MANY OF THE COMPETITION BILLS WOULD BE SUBJECT TO AN UNPRECEDENTED DEGREE OF FEDERAL REGULATION.

Traditionally regulated by the states, the health insurance industry under many of the competition bills would be subject to an unprecedented degree of federal regulation. Under these proposals, only if plans obtain federal approval can they be certified and marketed as "qualified" plans.[32] The federal government must decide not only whether plans comply with federal minimum benefits for the low-option plan and the catastrophic insurance coverage requirements, but also, in the case of Gephardt-Stockman, whether they meet minimal financial viability standards. Similarly, the requirement in some proposals that insurers annually set aside an open enrollment period in which they generally accept all eligible persons—be they high or low risk—makes the federal government a national open enrollment police force for the health insurance industry, a role which, if properly performed, would demand a not inconsiderable regulatory bureaucracy.

The regulation of the insurance business is considered such an exclusive state prerogative that in 1980 Congress decided that the Federal Trade Commission should not be allowed to study it, let alone regulate it.[33] That competition advocates—avowed enemies of federal regulation—should seek to impose such extensive federal controls on this industry is exceedingly ironic. So is the provision in the Gephardt-Stockman bill that forbids any local or state action—including, for example, enactment of state hospital rate-setting programs[34]—which would prevent or impede the reforms the bill is supposed to enact.

To employers burdened with new federal requirements, the competition strategy may appear equally regulatory. Currently, employers are fighting Congressional efforts to make them offer their employees a greater choice of HMOs.[35] They would surely resist having to offer the many choices required under the competition strategy. Employers may also resent interference with the successful self-insurance schemes they have created over the past decade to control their health costs.[36]

Bills like Gephardt-Stockman purport to replace government decision making with consumer choice: "The [market] decision of each of the members of each community will substitute for mandatory ceilings imposed by the government."[37] Despite this pronouncement, governmental decisions about how much to spend on health care will remain. The government—not individual consumers—will ultimately decide how high (or low) to set the value of premium vouchers for low-income people and the ceiling on tax-exempt employer premium contributions.

The competition strategy would not eradicate federal regulation, but would only transfer it to other quarters. The issue is not whether government intervenes in the marketplace, but rather how and where it intervenes. Government surveillance of and involvement in the medical care system will always be necessary if important social goals—most notably, unimpeded access to quality health care—are to be met.

THE INEQUITIES OF A COMPETITIVE SYSTEM

Blaming the Victims of High Health Care Costs

Physicians, not consumers, make most of the major health care expenditure decisions—whether to hospitalize or treat on an outpatient basis, whether and when to discharge patients to other institutional settings or to their homes, whether to schedule revisits for treatment, and whether and what kinds of x-rays, tests, and drug regimens to order.[38] Yet, competition advocates seek to curb excess utilization, not by applying direct controls to providers—the major utilization decision makers—but rather by imposing additional out-of-pocket costs upon consumers. Competition bills are thus best described as "consumer restraint" proposals.[39] Imposing harsh consumer restraints "without in any way restraining the pricing power of the physicians," however, "is to blame the victim, not to promote 'competition.'"[40]

Discrimination Against Certain Types of Workers

Low-Income Workers—Market reformers correctly point out that workers in high tax brackets get more tax benefits from the tax exclusion of employer-paid health insurance premiums than do low-income workers. The solution offered in the competition bill, however, is worse than the problem. The employees least able to afford the adverse tax consequences of choosing high-option coverage are the low-income workers. They are the ones who would most likely be forced to buy low-option protection with high cost-sharing requirements. Since lower-income workers often have the greatest medical needs,[41] it would be highly unfair to force them into the dilemma of having to choose between paying the high cost-sharing requirements or forgoing needed care.

The high out-of-pocket expenditures that must be incurred to trigger full catastrophic protection would also disproportionately disadvantage low-income employees. Having to pay several thousand dollars before being eligible for catastrophic coverage could itself be catastrophic for all but the relatively affluent.

High-Risk Workers—The competition strategy could invite a serious adverse selection problem. Group insurance seeks to spread medical costs over all employees, and thereby protects high-risk workers from bearing the exorbitant costs of the insurance they need. A competitive system could encourage those who expect to use few services—frequently young, healthy employees—to purchase lower-option plans, leaving their high-risk, often older peers with astronomically high premium payments for the protection they feel they require.

Workers in High-Risk Workplaces—Almost all employment-related insurance is experience rated, *i.e.*, insurers base the group plan's premiums on the past claims experience of plan members. By limiting the tax exclusion for employer-paid premiums to a standard amount, the competition bills would penalize workers who must pay high premiums, not because they have chosen more comprehensive benefits or less efficient plans, but because they happen to work for an employer with a high experience-rated premium. If the source of high claims experience were an occupational hazard to which the employer has exposed the workers, it could be grossly unfair that workers must either forgo or be taxed for the comprehensive insurance such a hazard necessitates.[42]

Workers in High Medical Cost Areas—Uniform limits on tax-exempt employer-paid premiums would further penalize workers who happen to live in those areas where medical costs are particularly high, with correspondingly high insurance premiums.[43]

HOW THE POOR WOULD FARE UNDER A COMPETITIVE SYSTEM

Enthoven proposed his Consumer Choice Health Plan in 1977 as a competitive alternative to other national health insurance proposals then under consideration. As such, it included provisions to address the needs of the uninsured and the underinsured poor. More than 26 million Americans were without health insurance coverage in 1977.[44] In addition, most of the country's estimated 5 million undocumented aliens have no health insurance coverage.[45] Of those at or below the poverty line in 1979, a shockingly high 47% did not qualify for Medicaid.[46]

Current competition proposals vary considerably in the degree to which they offer health insurance protection for the uninsured and underinsured poor. The Durenberger bill does not address the needs of low-income individuals at all. The Jones and Martin bills would extend catastrophic coverage to the uninsured poor, but only after substantial out-of-pocket costs had been incurred. In addition, the Jones and Martin bills would give Medicare and Medicaid patients catastrophic protection some time after their benefits had been exhausted.

In contrast, the Gephardt-Stockman bill, like Enthoven's plan, would provide the uninsured poor with vouchers they could apply to the premiums of any competing qualified plan. After four years, state Medicaid programs could elect to buy into this program on behalf of their beneficiaries. However, because the Gephardt-Stockman proposal provides federal aid only for citizens and lawful resident aliens, it does not address the needs of those undocumented aliens without health insurance.

How low-income persons would fare under such a competitive system depends on whether they can 1) enroll in acceptable plans, 2) find providers to treat them, and 3) receive quality treatment if and when they do locate plan-reimbursable providers.

Access to Acceptable Plans

The average treatment costs for low-income persons substantially exceed those for the nonpoor because such persons are generally sicker than high-income people. For example, low-income people suffer from chronic illness as measured by disability days far more than middle- and upper-income people.[47] Average lengths of stay and admission rates also are considerably higher for the poor.[48]

Since the poor cost more to treat, a system of predominantly community-rated, capitation-financed health plans would have very weak incentives to enroll them. Plans forced to enroll disproportionately large numbers of low-income, high-risk individuals may be unable to compete with other plans whose lower costs reflect a healthier membership. Enthoven and others point to Project Health in Multnomah County, Oregon, as an example of how a competitive market system for health care could serve the poor. Under Project Health, the County's medically indigent were to choose among six comprehensive prepaid health plans. The Project paid most of the premiums, with enrollees paying a small share depending on the cost of the plan they chose and their family income.

As a barometer of the success of competitive systems in spreading the costs of treating the poor, Project Health presents a very gloomy forecast. Eleven percent of Project Health's clients were such high risks that they were not accepted by any of the six competing plans.[49] Many of those with long histories of illness elected to remain with their personal doctors and therefore chose to enroll in one of the two individual practice associations (IPAs), offering a choice of doctors, rather than in the closed-panel HMO alternatives. The somewhat higher premium payments which had to be borne by those enrolling in these two IPAs did not discourage 29% of Project Health's clients from enrolling in them.[50] As a consequence of the resulting adverse selection experienced by these two plans,[51] one eventually withdrew from Project Health and, after threatening a similar withdrawal, the other was granted a staggering 75% rate increase.[52] Such increases apparently prompted the plan's healthier clients to switch to less costly plans, a phenomenon which has increased the costs of treating the sicker clients who remain.[53] What results is not beneficial plan competition over enrolling the poor, but rather an extreme form of experience rating in which the healthy pay less and the poor and those who pay on their behalf pay more.

COMPETITION THEORISTS EXPECT VIGOROUS PRICE COMPETITION AMONG INSURANCE PLANS.

Recognizing that the poor generally have greater medical needs and therefore are costlier to treat, Enthoven recommends that the purchasing power of their government vouchers be high enough to ensure their acceptance into an adequate plan. In a similar vein, Project Health officials came to the conclusion that with its high-risk population, it must increase its per-capita subsidies to the higher-cost prepaid plans or face the possible withdrawal from the Project of all the participating prepaid plans.[54] Thus, anything short of increased payments for high-risk, low-income individuals, as the Project Health experience so painfully demonstrates, will generate little, if any, plan competition to enroll them.

The Gephardt-Stockman bill, unlike Enthoven's, would not adjust premiums upward for low-income individuals. Vouchers for the poor, like the cost of the premium for all others, would be based on actuarial categories of age, marital status, number of dependents, disabilities, and sex, but not of income. The poor would receive vouchers equal to the average premium in the area plus the average out-of-pocket expenses incurred by persons in the same actuarial category. Plans determined to control treatment costs would hardly compete vigorously to enroll the poor if the vouchers for low-income people were based on the actuarial experience of all people—rich as well as poor—in the same category.

The only available tool in the Gephardt-Stockman bill to counteract plans' economic disincentives to accept the poor is, ironically enough, a regulatory one—open enrollment. For a disturbingly short one-month period every year, plans must generally accept all applicants, regardless of health status. Given the less-than-stellar performance of the Office of HMOs in enforcing the open-enrollment requirements of federally qualified HMOS,[55] and the large number of plans to be monitored, the prospects for vigorous enforcement of the open-enrollment provision in an increasingly anti-regulatory political climate would hardly be good. Worse yet, the bill would permit plans, with the approval of the Secretary of HHS, to limit the number of high-risk applicants they enroll if a "disproportionate" number apply for membership.[56] This distressingly vague provision is an open invitation to plans to seek such an exemption.

Access to Plan-Reimbursable Providers

Access to care under a competitive system presumes not only enrollment in a qualified plan, but also access to that plan's providers. Competition proponents confidently predict that "market forces can operate to distribute providers by making money available to every American in every part of the country to purchase health care from Qualified Plans and thus to attract providers."[57] Giving consumers the "purchasing power for health is meaningless," however, "if they do not have any available supply of health professionals or systems working in a responsive delivery system."[58]

So long as plans need to minimize their treatment costs to be competitive, they have little incentive to contract with providers located near and willing to serve low-income, high-risk populations. As Bruce Spitz's critique of HMO enrollment of Medicaid beneficiaries suggests, plans can be assured of avoiding the kind of adverse selection which plagued some of the HMOs participating in Project Health only if the plans' contracting providers operate in non-poverty areas inaccessible to such high-risk populations:

> *A basic problem with the Medicaid HMO strategy is that Medicaid clients are not evenly distributed throughout the state. Clients tend to be concentrated within the inner cities of large metropolitan regions. If HMOs are to be accessible to this group of recipients, they must locate near or within poverty neighborhoods. At the same time, such a location discourages enrollment of non-Medicaid members.*[59]

Thus, even if under a competitive system plans would enroll large numbers of the poor, they would still lack strong incentives to offer them geographically accessible clinics, hospitals, and health professionals.

Low-income consumers who remained without access to mainstream providers—including those who were able to enroll in qualified plans—would often be forced to continue their reliance on public hospitals as their providers of last resort. Thus, public hospitals would continue to be the main source of ambulatory and emergency as well as inpatient care for the inner-city poor and even some of the insured poor. But more and more public hospitals, because of huge operating losses from the large amounts of free care and low-paying Medicaid services they dispense to their indigent populations, are being forced to close by cities faced with shrinking tax bases and rising costs. A system of aggressively competing insurance plans would in no way help to reverse the trend to close public hospitals,

THE AVERAGE TREATMENT COSTS FOR LOW-INCOME PERSONS SUBSTANTIALLY EXCEED THOSE FOR THE NONPOOR BECAUSE SUCH PEOPLE SUFFER FROM CHRONIC ILLNESS FAR MORE THAN MIDDLE- AND UPPER-INCOME PEOPLE.

even though these hospitals would still be needed for the low-income segment of the population.

If anything, in fact, the competition strategy would accelerate the death of these badly needed institutions.[60] Highly competitive, profit-motivated plans will have few, if any, incentives to include among their limited number of providers those institutions which predominantly serve high-risk, low-income populations. In addition, none of the competition proposals requires plans to include such providers. Their exclusion from a system dominated by competing plans may just hasten their demise.

If the reimbursement of doctors and hospitals under a competitive system were to be based on their plans' ability to control costs, many of them would have very weak incentives to join plans with large numbers of high-risk enrollees or with several providers located in and serving high-risk areas.[61] As institutions serving the inner city continue to close, the inaccessibility of other private providers to low-income enrollees becomes an even graver problem. This problem would be further compounded by a proposal like Gephardt-Stockman which, in its de-regulatory fervor, would relieve most institutions of any Hill-Burton obligations to provide free care and community services for the poor.[62] What may ultimately happen to the underserved, if a competition proposal is adopted, is that they will be deprived of even the few providers who are currently available to them.

Access to High-Quality Treatment

The problems which the poor face with regard to the quality of their treatment under the competitive system would be very similar to those already experienced with health maintenance organizations. In general, these problems might be categorized as "undertreatment" and "underutilization."

THE COMPETITION STRATEGY WOULD ACCELERATE THE DEATH OF BADLY NEEDED PUBLIC HOSPITALS.

Incentives for undertreatment—which are always present to some degree in a prepaid plan as a means of controlling expenditures—are greater when treating the poor than the nonpoor. Allowed to enroll in prepaid plans only so long as they remain eligible for public assistance, the poor tend to disenroll from such plans far more than other enrollees.[63] Since such patients may not be eligible for plan coverage by the time they require costly care, prepaid plans may have less incentive to provide them long-term health maintenance services.[64] Such disenrollment patterns could also reduce a plan's incentive to give quality services in order to have a satisfied client who remains in the plan.

Low-income enrollees may be limited in seeking adequate care from aggressively competing plans because often the optimal use of such delivery systems requires that consumers be informed and assertive with regard to their own care. The history of Medicaid enrollment in HMOs has not shown the poor to be as "well-schooled in institutional confrontations [as in the case of demanding care] as are more affluent middle-class consumers."[65] One study found that enrollee utilization of the Kaiser plan in Los Angeles related directly to enrollee education levels, and conjectured that low-income members with less education underutilized the HMO because they, unlike more affluent, middle-class enrollees, did not know how to work the bureaucratic system.[66] In another study, low-income enrollees in poor health in an HMO perceived themselves as having considerably less access to nneded care than a comparison group insured under the conventional Blue Cross/Blue Shield plan.[67]

The competitive system may thus end up further limiting services to the already medically underserved. Additional regulatory efforts such as utilization review and quality assurance—measures that are shunned by competition advocates—would be essential to guard against the twin problems of provider undertreatment and enrollee underutilization.

THE CONSUMER STRATEGY UNDER A COMPETITIVE SYSTEM

> *By dispersing buying power among people, [a consumer choice plan] weakens consumer choice. The way to get consumer choice in health care and medical care is by organizing consumers in ways which will force a monopolistic, mystifying professional group to give them the services that they need. If the providers are organized and the people purposely disorganized, and the power to make the system responsive and responsible is thereby dispersed and divided, the power for choice is effectively lost.*
>
> *Victor Sidel*[68]

Advocates of the competition strategy claim that it will leave the decisions on the quality, size, and shape of the medical care delivery system to the marketplace. Under a competitive system, they say, consumers are "free to choose." But what options are consumers free to choose? Only those furnishing sufficient economic incentives to make providers willing to offer them. As Enthoven himself unabashedly admits, the competition strategy offers the medical profession "the surest basis for maintaining its autonomy" from external, regulatory, controls.[69]

Consumers can only ensure that appropriate, community-based medical care is available if they organize to control medical resource allocations and quality-of-care decisions themselves. The cumulative effect of consumers all making individual medical market choices is no substitute for direct, unified pressure on providers to deliver accessible, high-quality, and reasonably priced medical care. Consumers already have a strong need to develop organizations and coalitions with the buying power, political visibility, and clout to exert such pressure. Under the competition strategy such organizations and coalitions will continue to be essential if consumers are truly to gain power over the medical çare system.

Footnotes

1. A. C. Enthoven, "Consumer-Choice Health Plan," NEJM 298:650 and 298:709 (March 23 and March 30, 1978).

2. "Phasing Out Federal Regulation of the Health Care Industry," America's New Beginning: A Program for Economic Recovery, Feb. 18, 1981, at 6-22.

3. S. 1590, the Comprehensive Health Care Reform Act, introduced by Senator Schweiker last year, has been reintroduced as S. 139 by Sen. O. G. Hatch (R-Utah); S. 433, the Health Incentives Reform Act, was reintroduced by Sen. Durenberger (R-Minn.); H.R. 850, the National Health Care Reform Act, was reintroduced by Reps. R. A. Gephardt (D-Mo.) and D. Stockman (R-Mich.). Bills were also introduced last year by Rep. Ullman (H.R. 5740), Rep. Martin (H.R. 6405), and Rep. Jones (H.R. 7528).

4. Most of the bills do not affect health insurance purchased by individuals, probably on the theory that these persons are already motivated to buy cost-effective plans since the premiums are paid out of their own pockets.

5. Employer contributions are projected to total $59 billion in 1981. Congressional Budget Office, Budget Issue Memoranda,

Analyses of Several Major Budget Issues for the Fiscal Year 1982 Budget, Feb. 1981, at 76.

6. At an average marginal tax rate of approximately 43% (31% average individual income tax and 12% employer and employee payroll tax), this amounts to a $25 billion subsidy for fiscal 1981. Congressional Budget Office, id.

7. Only companies with a minimal number of employees are subject to the requirements of the various bills. This number varies among the bills.

8. See the Jones, Hatch, and Ullman bills.

9. The expenditure ceiling varies from $2,000 in the Ullman bill to $3,500 in the Jones bill. The Hatch bill sets it at 20% of the employee's annual income.

10. A. C. Enthoven, Health Plan, Addison-Wesley Pub. Co., Reading, Mass., 1980, at xii.

11. One of four essential principles in Enthoven's plan is the association of a health care financing plan with a limited set of providers. A. C. Enthoven, "The Competition Strategy: Status and Prospects," NEJM 304:110 (Jan. 8, 1981).

12. Independent fee-for-service physicians, reluctant to court substantial financial risk or surrender any of their economic and professional autonomy, vehemently oppose any system which they believe pressures them into forming aggressively competing economic units. E. Ginzburg, "Competition and Cost Containment," NEJM 303:1112 (Nov. 6, 1980).

13. High-cost hospitals fear movement toward any system calling for competition-based or low unit costs. "AHA Endorses Some Consumer Choice Tenets," Wash. Rept. Med. & Health/Finance Letter, Feb. 9, 1981, at 2. A. McMahon, President, AHA, Proposals to Stimulate Health Care Competition, Hearings before Health Subcomm. of S. Finance Comm. on S. 1968, 1980, at 145 (hereafter cited as Senate Hearings). Although the American Hospital Association has endorsed some "consumer-choice" principles—most notably employer offerings of multiple group health plans and changes in the tax status of employer-paid premium contributions—it has not voiced support for replacement of retrospective, cost-based reimbursement by competing units of plan-financed providers.

14. M. J. Roberts, "Planning and Competition in Health Care Delivery," paper presented at Am. Health Planning Assoc. Annual Meeting, San Francisco, Cal., June 1, 1980, at 10.

15. Id., at 11.

16. S. L. Simler, "Competition In, Regulation Out in Health Reform Proposal," Modern Healthcare 10:38 (June 1980).

17. A. C. Enthoven, "Competition of Alternative Delivery Systems," in Competition in the Health Care Sector: Past, Present, and Future, W. Greenberg, ed., Proceedings of a Conference Sponsored by the Bureau of Economics, Federal Trade Commission, March 1978.

18. H. S. Luft, "HMOs and the Medical Care Market," in Socioeconomic Issues of Health, AMA, Chicago, 1980, at 91.

19. For example, ever since it was started by the American Hospital Association, Blue Cross has been extremely intimate with the hospital industry. See S. A. Law, Blue Cross: What Went Wrong? Yale Univ. Press, New Haven, 1974.

20. Providers have been able successfully to thwart insurer efforts to control their market behavior. The classic case is that of the Aetna Life and Casualty Company which tried to enforce rate schedules for medical services. They made an agreement with their policy holders that in cases where a doctor's fee was partially disallowed for exceeding prevailing limits and the doctor eventually sued the patient for refusing to pay the balance him/herself, Aetna would defend the suit. In the face of a threatened doctor boycott, the insurer retreated.
"He Challenged Aetna's Hard-Line Fee Policy—and Won," Medical Economics (Sept. 11, 1972), at 31; Letters to the Editor, Medical Economics (Dec. 4, 1972), at 27.

21. W. J. McNerney, "Control of Health-Care Costs in the 1980's," NEJM 303:1088 (Nov. 6, 1980), at 1090; W. J. McNerney, Senate Hearings, supra n. 13, at 166.

22. "Study of Cardiac Surgery Raises Quality of Care Issues," PSRO Letter 7:6 (Nov. 15, 1979).

23. Enthoven limits disclosure requirements to information on premiums and benefit coverage. See supra n. 10, at 129-30. HHS Secretary Schweiker, when still a senator, introduced a bill to exempt PSRO data from the disclosure requirements of the Freedom of Information Act. S. 526, March 1, 1979.

24. Roberts, *supra* n. 14, at 12.

25. *Supra* n. 17, at 345.

26. H. S. Luft, "Assessing the Evidence on HMO Performance," *Milbank Mem. Fund Quarterly/Health and Society* 58:501 (Fall 1980), at 526.

27. In the Federal Employees Health Benefits plan, government employees are offered a wide array of partially federally subsidized plans, including commercial insurance, Blue Cross/Blue Shield policies, HMOs, and a union-sponsored plan.

28. Office of Personnel Management, Report to Congress, "Federal Fringe Benefit Facts, 1979."

29. Statement of Congressman Jones, Congressional Record H4680 (June 9, 1980).

30. W. J. McNerney, *Senate Hearings*, *supra* n. 13, at 155.

31. H.R. 850, §4(5).

32. Competitive market advocates oppose largely unregulated, overly free market entry of health care plans as a threat to the success of their entire program. As Enthoven writes: "If there are too many third-party intermediaries, then none of them will represent a large enough percentage of hospitals' or physicians' business to be able to influence the providers' behavior." *Supra* n. 17, at 347. However, governmental control, even Enthoven concedes, "would mean a susceptibility to all kinds of transient political influences, perhaps the most dangerous of which would be pressure from established health plans to keep out new competitors." *Health Plan*, *supra* n. 10, at 143.

33. Section 5 of P.L. 96-252, the Federal Trade Commission Improvements Act of 1980.

34. *See* "Changes Made by the National Health Care Reform Act of 1981 (H.R. 850)," at 7. (Rep. Gephardt's office)

35: "HMO Legislation Is Pro-Competition Testing Ground," *Wash. Rept. Med. & Health/Planning Letter*, April 13, 1981.

36. *See* O. H. Delchamps, Jr., for the Chamber of Commerce of the U.S., *Senate Hearings*, *supra* n. 13, at 297.

37. *Supra* n. 31.

38. "Doctors Play Key Role in Determining How High Health Costs Climb," *National Health Insurance Rept.*, Nov. 16, 1979.

39. "HCMR Interview: Michael D. Bromberg, Esq.," *Health Care Management Review* 5:91 (Fall 1980).

40. A. G. Schneider, *An Advocate's Guide to Health Care Financing*, Legal Services Corp., May 1980, at 49.

41. *See* notes 47-48 *infra*.

42. Occupational hazards might push up employees' group health costs, particularly since, as a recent Labor Department study concluded, workers' compensation plans frequently do not reimburse the medical costs of the victim of occupational injury or disease. U.S. Dept. of Labor, Asst. Secretary for Policy Evaluation and Research, *An Interim Report to Congress on Occupational Diseases*, June 1980. When workers' compensation does not reimburse for such costs, group health plans could be forced to pick up the slack, as a study of an unusual union-sponsored occupational hazard screening program illustrates. By identifying occupational disease victims whose medical bills should be paid by workers' compensation rather than by union health funds, a local New York printers' union was able to eliminate a $350,000 union health fund deficit within two years. F. Goldsmith, "Local Union Cost Savings Program: Screening Off-the-Job Disability Claims for Workers' Compensation Injuries and Diseases," Guide No. 12 in *Local Union Hazard Control Handbook*, Labor Safety and Health Inst., NY, 1979.

43. Unwarranted geographic variations in utilization patterns and physician pricing behavior have often been found. *See*, for example, T. Bogue, *Why Not the Most*? Public Citizen Health Research Group, Wash. DC, 1977.

44. National Center for Health Services Research, "Who Are the Uninsured?" *Data Preview* 1, National Health Care Expenditures Study, at 1.

45. J. Siegel, *et al.*, *Preliminary Review of Existing Studies of the Number of Illegal Residents in the U.S.*, Bureau of the Census, U.S. Dept. of Commerce, Jan. 31, 1980.

46. Health Care Financing Administration data reprinted in "Severe Financial Problems Beset Many States' Medicaid Programs," *American Medical News* 24:16 (Jan. 30, 1981).

47. P. Newacheck, et al., "Income and Illness," *Medical Care* 18:1165 (Dec. 1980).

48. In one study, average lengths-of-stay 43% greater for the lowest income group than for the highest have been found. Admission rates varied by more than a factor of two between these groups. M. Rudov and N. Santangelo, *Health Status of Minorities and Low-Income Groups*, DHEW, Pub. No. (HRA) 79-627, at 232.

49. N. R. Eder, "Health Care in America: How Did We Get Here? Where Do We Go?" *A National Health Policy and Planning Seminar with Focus on Project Health*, Feb. 23-24, 1981, Portland, Ore., at 1.

50. Thirty-six percent of the enrollees surveyed indicated that preserving a prior relationship with a physician was the most important factor they considered in choosing a plan. Touche Ross & Company, *Oregon Adult and Family Services Division: Third-Year Evaluation of the Medicaid Demonstration Project in Multnoman County, Final Report*, Sept. 30, 1979, at 45.

51. The IPAs' inpatient utilization rates were more than ten times that of the Kaiser option. *Ibid*., Appendix A, at 12. Some—though certainly not all—of the disparity between these utilization rates may be due to the differences in the structure of these HMOs.

52. "Project Health in Transition," *supra* n. 49, at 9.

53. *Supra* n. 50, at 47.

54. *Supra* n. 52.

55. Besides citing the Office of HMOs for its lackadaisical enforcement of open enrollment and other federal requirements, the GAO criticized the agency for its disorganization and lack of staff expertise. GAO, *Can Health Maintenance Organizations Be Successful? An Analysis of 14 Federally Qualified "HMOs*," HRD-78-125, June 30, 1978, at 4.

56. H.R. 850, §203(c)(4).

57. *Supra* n. 34, at 9-10.

58. E. Martin, "Consumer Choice Health Plan Impact on Rural America," in National Center for Health Services Research, *Effects of the Payment Mechanism on the Health Care Delivery System*, Proceedings of a Conference, Nov. 7-8, 1977, Pub. No. (PHS) 78-3227, at 49.

59. B. Spitz, "When a Solution Is Not a Solution: Medicaid and Health Maintenance Organizations," 3 *J. Health Politics, Policy and Law* 497 (Winter 1979), at 510.

60. HMO financing structures could offer public hospitals the potential for a far more stable and adequate level of funding than can the fee-for-service system. B. Ensminger and S.A. Law, "Public Hospital-Based HMOs," 6 *HLP Library Bull*. 33 (Feb. 1980). However, when public control is surrendered to private plans aggressively competing to minimize their costs, public hospitals may be excluded from most capitation-financed contracts altogether.

61. Jack R. Anderson, Chairman of the Board of Hospital Affiliates International, concedes that investor-owned hospital chains do not build hospitals in the inner city for fear of "drown[ing]" under the weight of the inner city's particularly serious health care "problems." E. Friedman, "The Hospital as a Business: Suspect or Sensible" *Hospitals* 55:60 (March 1, 1981).

62. If members of qualified plans account for at least one-half of an institution's annual patient-days, that institution is relieved of its Hill-Burton free care and community service obligations in the following year. Section 306(c) of H.R. 850.

63. For example, one study estimated that 36% of the Medicaid recipients in New York City disenrolled from HMOs within one year, more than twice the non-Medicaid rate. J. Hester and E. Sussman, "Medicaid Prepayment: Concept and Implementation," *Milbank Mem. Fund Quarterly/ Health and Society* 52:415 (Fall 1974), at 425.

64. B. Spitz, *State Guide to Medicaid Cost Containment*, Center for Policy Research, Off. of Research Studies, National Governors Assoc., at 37.

65. *Ibid*.

66. R. Hetherington, *et al*., *Health Insurance Plans: Promise and Performance*, J. Wiley and Sons, 1975, at 117 and 127.

67. W. Richardson, et al., *Comparisons of Prepaid Health Care Plans in a Competitive Market: The Seattle Prepaid Health Care Project*, National Center for Health Services Research, Research Summary Series, Pub. No. (PHS) 80-3199, Aug. 1980.

68. V. Sidel, "Comment," *supra*, n. 58, at 82.

69. *Supra* n. 1, at 720.

□

Chairman Jacobs. Thank you, Mr. Sigelman. You went over 1½ minutes.

Mr. Clayman.

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Clayman. Mr. Chairman, I represent the National Council of Senior Citizens. The problem that the committee is obviously wrestling with is so complex, so untried, that it is difficult to intelligently grapple with it.

I suspect the avowed thesis or the purpose of the various bills is to somehow bring down the cost of health care. That is a worthy cause, because we have worried about that. Elderly citizens, in spite of medicare, are deeply concerned with rocketing health costs but the remedies can be achieved by Congress in other more direct ways.

I can remember, for example, the bill before Congress not so long ago that attempted to hold down accelerating costs of health care in America and that bill was defeated.

Now, apparently we are reaching out as far as we can in every possible area, trying to find a remedy when the remedies are available in other directions.

I am sure you are aware that senior citizens have a special concern about the cost of health care.

First, we pay roughly three times more for health care than any other segment of the population. Medicare only takes care of something slightly below 40 percent of health costs.

And so we would like to see serious congressional cooperation in the area of making social security and its auxiliary medicare more effective, because we are spending too much of our hard-earned money on health care.

The thesis of this bill is that it will achieve, or these bills will achieve, competition. I suspect that competition presupposes some kind of equality between the parties who trade in the marketplace. Where you have parties that have much greater strength in the marketplace than others, you will never achieve equality or fair play because there is no proper division of strength among those in the marketplace.

What am I talking about in this field—the consumer has little bargaining power in terms of buying medical care. I am told that I am reasonably competent—though some may doubt it—and yet I know nothing about medicine. I cannot, in any way, compete with the provisions of health care.

I don't seriously know the qualifications of the doctors, I can't make sensible decisions in that area. I think I do but I really don't. So the plain fact is that the consumer is not a serious force in this important phase of the marketplace. The doctor makes 70 percent of all the medical decisions and with that kind of authority, that kind of power, there is no serious input or competition on the part of the consumer.

It obviously is true that insurance companies will be involved very seriously and deeply in the voucher system approach. The competition among them will be as to which can make the greater profit.

Now, then, there are ways out. For years I have watched HMO's, I have watched the method by which they run, I have watched their cost mechanisms. I have discovered, for example, that they have eliminated an enormous number of unnecessary days spent by patients in hospitals.

They have brought down basically the cost of medicine while they have maintained quality. And I ask myself why is this so? And one of the reasons is that the consumer does have the power, does have influence within prepaid health organizations offering comprehensive care. They have that kind of power because they sit on boards of HMO's making basic decisions.

Now then, in a situation like that, there is competition and if Congress were to make the determination to spend the money, to encourage and develop more HMO's of the proper kind, we could have a competitive system. That system versus the private and individual system of health care that we have now And at least, in my judgment, these are the areas that need careful research.

Medicare is going to be hurt. If this so-called competitive system, where the marketplace rules, becomes the law of the land, medicare is going to be hurt. I suspect that some intend to use these bills to eliminate the medicare system, and if that came to pass it would be a sad time in American medical history in our society.

Medicare is doing an immensely important and effective job, save and except that it pays too little of our hospital bills and the medical bills.

So if I were a Congressman, and I am not—not likely to ever be—I would spend my time looking at these other practical alternatives. There is little history, there is little experience, indeed, as far as I know, maybe no serious experience in the area of this kind of allegedly competitive voucher system.

So we are probing in the dark when there are practical other alternatives available. I haven't heard a bell but I guess it is 5 minutes.

[The prepared statement follows:]

STATEMENT OF JACOB CLAYMAN, PRESIDENT, NATIONAL COUNCIL OF SENIOR CITIZENS

Mr. Chairman, members of the Committee, I am Jacob Clayman, President of the National Council of Senior Citizens. I am here today to speak on behalf of our membership of over 4,000 affiliated clubs and councils throughout the country, representing over four million senior citizens.

Thank you for this opportunity to talk to you about the proposals to stimulate competition in the delivery and financing of health care.

I am here today on behalf of our members because health care is one of their greatest needs. The elderly are the population group most likely to need comprehensive health care, and their health care expenses are three time greater than those of any other age group.

The elderly encounter problems in today's health care system. Most of these problems can be related to the health system's structure which is oriented toward expensive and institutionally-based care. Consequently, many of the elderly's long-term and chronic health needs are not met, and the elderly must pay too much for services.

Although the Medicare program fails to meet many of the elderly's long-term and chronic health care needs, people over age sixty-five do depend heavly on Medicare, particularly to meet their acute care expenditures. The competition proposals would extensively reform Medicare, and it may be the first element of the health care system to which competition strategies would be applied.

Senior citizens, therefore, have the most to gain when the Congress makes major decisions about health care. They also have the most to lose when ill-advised policies are adopted.

Now, why is this concept of competition being considered? As I see it, our public policy makers are looking for a solution to the problems in our health care system. Competition, with its emphasis on private market forces and consumer choice, seems to be in vogue.

There are many alternative solutions, some good and some not so good, and you probably will hear about all of them during your hearings. The optimal solution should be one that renders society better off, one that gives all people access to an improved health care system, and one that gives us better value for our public and private health care dollars.

The health care of a society is a very serious public issue. Holding the first of the competition hearings, Mr. Chairman, is testimony to your understanding of the importance of this matter.

I sincerely hope that as you listen to the witnesses and deliberate on their expert advice, you will seek the answers to some very basic but critical questions. I believe that certain questions must be answered in order to make decisions on the competition proposals. I would like to pose some of these questions myself, and, with your permission, offer some answers.

What is the problem we are trying to solve?

The health care system is costing more and more, but Americans are not necessarily getting more or better care.

The cost of health care is consuming an increasingly greater percentage of our national resources.

The cost of health care is being shifted to a greater and greater extent to consumers of health care as the value of Medicare (and, to some extent, all third party coverage) erodes.

The cost increases in health care are an important element of general inflation.

Why does the health care system cost so much?

The structure of the delivery and finance of health care is such that providers are not accountable for the costs of decisions they make.

There are no built-in incentives for providers or patients to keep costs down. Specifically, perverse incentives are a result of the retrospective fee-for-service reimbursement and the prevalence of third-party payment.

Why is it necessary to correct these problems soon?

The increasing public and private costs are a burden on the national economy. At least one-half of the federal budget for health is spent on the Medicare program. The program does not meet the elderly's health care needs adequately today, and the program will be further eroded as health care inflation continues. The Medicare funds will be insufficient following the end of this decade. Instituting reforms now will protect the Medicare beneficiary and prepare for a growing aged population.

What will "competition" try to accomplish?

It is alleged that economic efficiency in the health care system will be achieved if consumers are aware of the price of services.

Reduced federal expenditures for health care.

What is the major provision in the competition proposals which is designed to reach these goals?

The fixed dollar subsidy or voucher. Although this differs somewhat from plan to plan, all health care consumers would receive a specified amount of money annually to buy a qualified health insurance plan from the private market. Medicare beneficiaries are included in this plan. Their voucher value at the outset is likely to be the average per capita cost of the Medicare program. (Today this is about $1,700.)

Competition proponents claim that giving a fixed subsidy would force the cost of health care downward. They expect that the consumer will shop around to get the best deal for his/her voucher dollar. Proponents expect the insurers will compete for voucher dollars by offering the most attractive benefit packages at the lowest price. The insurers, the theory goes, will force the providers to operate in an economically efficient manner.

Will a voucher system reach these goals?

I think that it will not. Applying a voucher system to Medicare or the health finance system in general seems to be an attempt to solve a problem that vouchers cannot solve.

As I understand vouchers, they are used to give low-income people additional purchasing power. The voucher enables them to purchase in the open market the goods which society has determined all people should have, but which they otherwise would not be able to obtain. Food stamps are vouchers. They enable poor people to buy a better diet.

A Medicare voucher would only change the way health care is purchased. It would not enable more elderly people to buy health care nor would it buy them better health care. It would very likely cost the government more money, or not reduce overall public and private health expenditures.

The health care system lacks the conditions under which a voucher system works best. The major requirements are that the consumer be knowledgeable, well informed, and able to recognize the quality of the goods. The goods must be such that their quality is easily identified and measured. The product must be relatively inexpensive so that people buy it frequently enough to learn from their experiences. The sellers of the goods must be interested in obtaining the voucher dollars.

This is hardly an environment for a Medicare voucher. Don't we really need to improve the product and solve the inherent problems, not just throw money at them?

Why are Medicare vouchers being proposed?

The only explanation I can find is to take out of the federal budget much of the expense of providing health care to the elderly.

Will competition in health care accomplish what its proponents predict it will?

Again I would answer: I think it will not.

The health market lacks the basic characteristics of a truly competitive market, and artifically imposing competition criteria upon it will not change its behavior. Critical elements are missing.

The health consumer lacks full market information and cannot adequately judge quality. Simply knowing prices, providers, or benefits is not sufficient. Complete technical and scientific knowledge would be required for the consumers to make fully informed decisions.

Even a significantly knowledgeable consumer would not markedly alter the market. It is the physician who makes 70 percent of the health care decisions. The consumer's role is very small, and his decisions are usually in areas where costs are low.

What solutions will really address the problem and bring about the desired goals?

The major question here concerns: How can we reduce the growth of health care spending while best helping the health care consumer?

We are not here to advocate throwing more money at the problem. In our view, the use of vouchers may end up as just a way of throwing money at a problem without effecting any needed reforms. If the goal is a more efficient and effective health care system that is physically and financially accessible to every person in the country, without using up an uncomfortable share of our national resources, then the correct policy must include the concept of prospective budgeting.

This is not a new concept. It is constraint imposed on every business in the private sector. Business people must make efficient decisions within a budget constraint because they will not stay in business if they don't. This basic rule of operation is what we observe in most of the private sector, but not in the health care delivery and reimbursement system. It is this feature of the private sector that we must introduce into the health care system if we are to make any beneficial changes in the system. Vouchers will not get us there.

Chairman **Jacobs**. Yes, sir, I think it is.

I thank the panel entirely and specifically Mr. Clayman. Your testimony is very eloquent and I would imagine very persuasive. Thank you.

Mr. Gradison will preside.

Mr. **Gradison**. Thank you very much.

We will proceed, then, with the next panel, Dr. Donald F. Schaller and Robert J. Erickson.

Dr. Schaller, would you proceed.

STATEMENT OF DONALD F. SCHALLER, M.D., VICE PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Dr. SCHALLER. Mr. Chairman, I am Dr. Donald Schaller, vice president of the Group Health Association of America, also co-executive director of the Arizona Health Plan.

I would ask that you enter into the record the full statement we submitted earlier. My remarks that follow represent a summary of those comments. GHAA represents most of the prepaid group practice plans in the Nation; over 100. Our members serve in excess of 7 million enrollees, nearly 80 percent of the total national HMO enrollment.

We appear here today as a proven competitive element in the health care field. Total national membership in HMO's approaches 10 million people in over 200 plans.

Studies have confirmed what we have long known—that a competing health care system could have a restraining effect on health care costs and indeed could impact on ever rising costs in the predominant fee for service third party payment system. One of these studies even indicated that where more than one HMO exists in a community the competitive effect is greater.

It is important that those who support the new competition proposals understand our place in the health care delivery system from a realistic perspective. I want to make it clear that we have never considered ourselves either the sole or the primary answer to the problems of the Nation's health care system, but we have demonstrated that we should be a significant component of any market oriented health care strategy.

By delivering care for a fixed prepayment through an organized direct service system, we create incentives to use health care resources in the most efficient and appropriate manner without sacrificing quality. Prepaid group practices achieve major cost savings including hospital utilization rates which are significantly lower than comparable fee for service utilization—and our mode of providing health care has an impact upon the rest of the health care community.

Our main concern with respect to the development of pro-competition legislation is that such legislation permit us to continue to exist as a viable choice.

The feature of the competitive strategies currently being discussed which gives us the most concern is the cap on the tax benefits to employers and employees flowing from employer contributions toward health coverage. We are fearful that, depending upon the level at which the tax caps are set, the incentives created may cause employers to offer, and healthy employees to select, less comprehensive health benefits—the lower the cap, the more pronounced these incentives. Since comprehensive benefits are basic to our system and required by law, an obvious bias against us would be created, and our ability to compete would be lessened.

A further danger to the competitive position of comprehensive plans would be the dramatic increase in adverse selection. Rates for HMO's and other comprehensive coverage would rise, perhaps until they are out of reach, and the gap between such coverage and that selected by the preferred risks would gradually widen.

On the other hand, the consumer who made a decision to purchase minimal coverage when he or she was healthy might be faced with unmanageable costs if serious illness occurs.

Perhaps the most socially damaging aspect is that consumers who are healthy and want to provide for their protection would be discouraged from doing so by prohibitive rates.

If Congress decides to make tax caps an element of pro-competition legislation, it is important that the tax limitations be set high enough to allow plans offering reasonably comprehensive benefits to compete with other plans on an equitable basis. It is equally essential that such tax caps be set on a geographical basis because of the great disparity of health care costs in various areas of the Nation. In conjunction with such tax caps, a requirement that benefit packages be reasonably comprehensive would both permit equitable competition among health plans and give consumers a true option to select adequate coverage.

Cash rebates, particularly when combined with a low tax cap could create problems similar to those potentially created by tax caps alone.

Informed choice underlies the competition strategies. Ten years of experience under the Federal HMO Act has proven that the choice of a comprehensive prepaid direct service system can have enormous advantages for the consumer and a significant impact on the health care market. Further, if true competition is based on informed choice, it is essential that the options available include alternatives to fee for service third party payment systems. The only way to accomplish this is through a continuation of our present national policy of including HMO's in the range of available choices.

Another procompetitive proposal involves the conversion of medicare and medicaid to a voucher system. A soundly constructed system would augur well for those, like HMO's, who are cost efficient. But we seriously question whether vouchers proposed as a method of budget savings would be sufficient to afford the elderly the same level of health care which medicare provides them today. Inclusion of a cash rebate in such a voucher system would have a greater negative impact in the case of the elderly than in the general population because of their fixed and lower incomes.

Finally, Mr. Chairman, this subcommittee has before it legislation which would, if enacted, offer the elderly a greater choice of health care systems and an opportunity for broader coverage. Enactment of this legislation will give the elderly the advantages derived from true competition without the potential detriments of a voucher proposal.

Mr. Chairman, the 40-year history of the HMO movement has clearly proven that competition in the health care marketplace can have an advantageous effect on health care costs and can improve the quality and extent of health care services for the consumer. In constructing any new competitive strategy, Congress should take great care to make sure that HMOs and other alternative delivery systems continue to have an equitable opportunity to compete.

Thank you, Mr. Chairman.

Mr. **Gradison**. Thank you very much, Dr. Schaller.

[The prepared statement follows:]

STATEMENT OF DONALD F. SCHALLER, M.D., VICE PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA, INC., AND CO-EXECUTIVE DIRECTOR, ARIZONA HEALTH PLAN, INC.

Mr. Chairman and Members of the Subcommittee, I am Dr. Donald F. Schaller, Vice President of Group Health Association of America and Co-Executive Director of the Arizona Health Plan. Group Health Association of America represents most of the prepaid group practice plans in the nation, over 100, and our members serve in excess of 7 million enrollees, nearly 80 percent of the total national HMO enrollment.

We appear here today as a proven competitive element in the health care field. Total national membership in HMOs approaches 10 million people in over 200 plans. HMO growth rates are expected to continue, and indeed accelerate, as more and more people are faced with intolerable financial burdens—as they find they live in a society where the benefit packages being offered are shrinking as health plan rates increase and outstrip increases in their personal incomes. Mr. Chairman, our growth is impressive when one considers that less than ten years ago we were restricted or outlawed in over thirty states and our national membership was less than four million. If we had had the capital and management resources to immediately respond to the market, HMO development and growth could have been more dramatic over this period.

We were never surprised by our rapid development. Studies confirmed what we knew—that a competing health care system could have a restraining effect on health care costs and indeed could impact on ever rising costs in the predominant fee for service third party payment system.[1] One of these studies (FTC) even indicated that where more than one HMO exists in a community the competitive effect is greater.

It is no wonder that the competitive impact of health maintenance organizations in the health care marketplace has been the focus of serious interest and action in the Congress, as well as in the executive branch, and that HMOs are almost always mentioned in the ongoing efforts to develop new pro-competition strategies.

It is important that those who support the new competition proposals understand our place in the health care delivery system from a realistic perspective and that our competitive value be fully and accurately understood.

I want to make it clear that we have never considered ourselves either the sole or the primary answer to the problems of the nation's health care system, but we have demonstrated that we should be a significant component health of any market oriented health care strategy.

By delivering care for a fixed prepayment through an organized direct service system, we create incentives to use health care resources in the most efficient and appropriate manner without sacrificing quality. Basic to our system is improved access to care. Our members receive a comprehensive range of services without the economic barriers to early treatment which are found in the fee for service sector. Prepaid group practices achieve major cost savings including hospital utilization rates which are significantly lower than comparable fee for service utilization—and our mode of providing health care has an impact upon the rest of the health care community. Studies show that the development of a strong prepaid group practice often sparks creation of a competing IPA model HMO (sometimes sponsored by the local medical society) and that providers competing with HMOs are spurred to reduce costs by improving their own patterns of utilization.

HMOs provide a clear alternative, and a challenge, to the fee for service sector. We are the one proven competitive element in the predominantly fee for service health care marketplace today. Our main concern with respect to the development of pro-competition legislation is that such legislation permit us to continue to exist as a viable choice.

HMOs successfully compete in the existing market in which fee for service and third party payment are dominant. If the pro-competition legislation changes the current market structure through the establishment of new incentives, it will necessarily affect the competitive status of HMOs. Our value in the marketplace is that we can offer broader benefits at a cost comparable to or lower than our competitors and that we achieve our savings through a more economic use of health care resources. Any proposal providing incentives which negate our ability to complete on this basis robs the system of the constructive pressures we provide to hold down inappropriate utilization and costs. We strongly feel that any competitive system that puts comprehensive prepaid direct service systems at such a disadvantage runs counter to any goal of attempting to control health care inflation and yet provide adequate health care to those who need it. Thus, any competition proposal has to be drafted in such a way that efficient systems are encouraged and inefficiency is not rewarded.

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[1] "Staff Report on the Health Maintenance Organization and Its Effect on Competition," Lawrence G. Goldberg and Warren Greenberg, Federal Trade Commission, 1977.
"Selected Use of Competition by Health Systems Agencies," ICF, Incorporated, 1976.

The feature of the competitive strategies currently being discussed which gives us the most concern is the cap on the tax benefits to employers and employees flowing from employer contributions toward health coverage. We are fearful that if the Congress adopts the concept of limiting such tax benefits, the resulting incentive will be for the selection of plans which do not truly meet health care needs. Such incentives, depending upon the level at which the tax caps are set, may cause employers to offer and healthy employees to select less comprehensive health benefits—the lower the cap, the more pronounced these incentives. Since comprehensive benefits are basic to our system and required by law, an obvious bias against us would be created, and our ability to compete would be lessened.

A further danger to the competitive position of comprehensive plans would be the dramatic increase in adverse selection. The sick or those anticipating substantial health care costs would be the most likely to select the more comprehensive coverage offered by HMOs and other carriers. The result of such adverse selection would be a gradually increasing segmentation of the market. Rates for HMOs and other comprehensive coverage would rise, perhaps until they are out of reach, and the gap between such coverage and that selected by the preferred risks would gradually widen. Adverse selection means that the cost of health care will become prohibitive for those who need it the most.

On the other hand, the consumer who made a decision to purchase minimal coverage when he or she was healthy might be faced with unmanageable costs if serious illness occurs. We are deeply concerned that badly drawn tax caps would force consumers to choose between the immediate need for basic living necessities, such as food and housing, and the less immediate and less predictable but equally important need for health care. Under these circumstances the short term monetary advantage to the consumer would become merely cosmetic. Perhaps the most socially damaging aspect is that consumers who are healthy and want to provide for their protection would be discouraged from doing so by prohibitive rates.

If Congress decides to make tax caps an element of pro-competition legislation, it is important that the tax limitations be set high enough to allow plans offering reasonably comprehensive benefits to compete with other plans on an equitable basis. It is equally essential that such tax caps be set on a geographical basis because of the great disparity of health care costs in various areas of the nation. In conjunction with such tax caps, a requirement that benefit packages be reasonably comprehensive would both permit equitable competition among health plans and give consumers a true option to select adequate coverage.

Cash rebates would create similar problems, particularly when combined with a low tax cap. Again consumers struggling with high inflation would be faced with the choice between receiving cash in the short term in exchange for inadequate coverage or catastrophic expenses in the long term.

Cash rebates combined with a low tax cap would have an immediate disadvantage for HMOs and others who may directly provide comprehensive services. Competition between health services and cash payments is not competition at all, because the outcome is rarely in doubt. It would have the opposite effect from that expected by proponents, since cash rebates would in most cases act as a disincentive rather than an incentive to make an informed choice of appropriate health care coverage.

Informed choice underlies the competition strategies. Ten years of experience under the federal HMO Act has proven that the choice of a comprehensive prepaid direct service system can have enormous advantages for the consumer and a significant impact on the health care market. HMOs can act as a competitive yardstick by which plans with either similar or varying coverages can be measured. Further, if true competition is based on informed choice, it is essential that the options available include alternatives to fee for service third party payment systems. The only way to accomplish this is through a continuation of our present national policy of including HMOs in the range of available choices.

Another pro-competitive proposal involves the conversion of Medicare and Medicaid to a voucher system. We can understand how vouchers can be readily adapted to a competitive market strategy. Indeed, a soundly constructed system would auger well for those, like HMOs, who are cost efficient. But we seriously question whether vouchers proposed as a method of budget savings would be sufficient to afford the elderly the same level of health care which Medicare provides them today. Inclusion of a cash rebate in such a voucher system would have a greater negative impact in the case of the elderly than in the general population because of their fixed and lower incomes.

Finally, Mr. Chairman, this Subcommittee has before it legislation which would, if enacted, offer the elderly a greater choice of health care systems and an opportunity for broader coverage. H.R. 3399 provides for reimbursement of HMOs at 95 percent of the current cost to the government for providing Medicare benefits in the community. The legislation also requires that any savings generated by HMO efficiencies must be passed on to the elderly in the form of additional benefits. Enactment of this legislation will give the elderly the advantages derived from true competition without the potential detriments of a voucher proposal.

Mr. Chairman, the forty year history of the HMO movment has clearly proven that competition in the health care marketplace can have an advantageous effect on health care costs and can improve the quality and extent of health care services for the consumer. Congress was fully justified in providing for an expansion of this kind of competition through enactment of P.L. 93-222, the Health Maintenance Organization Act of 1973. In constructing any new competitive strategy, Congress should take great care to make sure that HMOs and other alternative delivery systems continue to have an equitable opportunity to compete.

Mr. GRADISON. We will now hear from Robert J. Erickson, senior vice president of the Kaiser Foundation Health Plan.

STATEMENT OF ROBERT J. ERICKSON, SENIOR VICE PRESIDENT AND COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC., AND KAISER-PERMANENTE MEDICAL CARE PROGRAM

Mr. ERICKSON. We have submitted a written statement which we would like to make part of the record.

Mr. GRADISON. Without objection, both of your statements will appear in their entirety in the record.

Mr. ERICKSON. Thank you. I will say just a few words about the principal subject of our statement.

It discusses a practical competitive approach for medicare beneficiaries, the purpose being to encourage beneficiaries to select efficient, cost-effective plans. It has the advantage of already having broad support which many of the competitive proposals have not developed to this date.

H.R. 3399 has been approved by the Energy and Commerce Committee and is waiting action by this committee. It is not a voucher proposal, but it includes a number of the perceived advantages and the perceived problems of the proposed voucher system.

A number of demonstrations are now in process involving this proposal, including one by our Oregon region, and these demonstrations have demonstrated its feasibility.

Enactment of H.R. 3399 would lead to further development of information and methodology that is needed and could be applied to any voucher system that may be adopted.

A similar bill was approved by the Ways and Means Committee and passed by the House in 1972.

Technical amendments to the bill passed by the Energy and Commerce Committee are set forth in page 9 of our written testimony. Other amendments may be appropriate based on the demonstration projects. H.R. 3399 is based upon a private sector initiative that has demonstrated efficiencies and cost savings in the delivery of health care.

It would permit these same principles to be applied under medicare. Basically it would reward beneficiaries for selecting cost-effective systems, it would encourage the development of competition in the health care industry and it would be a step toward developing knowledge about proposed medicare voucher systems.

Thank you.

[The prepared statement follows:]

STATEMENT OF ROBERT J. ERICKSON, SENIOR VICE PRESIDENT AND COUNSEL, KAISER FOUNDATION HEALTH PLAN, INC.

Mr. Chairman and Members of the Committee, I am Robert J. Erickson, Senior Vice President and Counsel of Kaiser Foundation Health Plan.

Kaiser Foundation Health Plan, Kaiser Foundation Hospitals and eight independent Permanente Medical Groups comprise the Kaiser-Permanente Medical Care Program. The Program is an economically self-sustaining, organized health care delivery system that provides health services on a prepaid, direct-service basis to over 3.9 million members in California, Colorade, the District of Columbia, Hawaii, Maryland, Ohio, Oregon, Texas, Virginia, and Washington. Kaiser-Permanente members receive services through 28 hospitals, 85 outpatient facilities, more than 4,200 full-time physicians and over 36,000 employees.

The Kaiser-Permanente Program is the largest health maintenance organization (HMO) in the United States. Its membership includes more than 200,000 individuals who are Medicare beneficiaries.

I would like to address my comments on health care competition to one particular segment of the population, the nation's elderly, and discuss how we believe the Medicare program could be strengthened in ways that would make it more competitive and reward its beneficiaries for choosing cost-effective HMOs in the process.

Medicare represents a key element of protection to which most of the nation's elderly are entitled by virtue of paying payroll taxes during their working years. However, this protection is being eroded because Medicare's cost-based reimbursement system rewards increased spending and does not provide necessary incentives for the effective delivery of health care services.

Medicare's failure to control costs also poses a serious problem for the federal budget and the President's commitment to balance it by fiscal 1984. The magnitude of the problem is apparent when one recognizes that Medicare expenditures are projected to rise more than 100 per cent from $35 billion to $75 billion, between 1980 and 1986. As a consequence, many organizations and individuals are calling for the reform of Medicare. Thus, the question before Congress is not whether to reform this massive federal health program, but just how it should be done.

Many approaches have been suggested to Congress and particularly to the House Ways and Means Committee, which has played a central role in overseeing the development and operation of Medicare. A few organizations, including the Reagan Administration, are discussing changing Medicare by permitting beneficiaries to buy health care benefits through the use of a voucher. The voucher amount would be some portion of the estimate of what it would cost an elderly individual to purchase a reasonably comprehensive health benefits plan from a private carrier. The beneficiary would be expected to pay part of the cost of these benefits and thus, it is assumed would become more cost-conscious.

Rather than discuss possible approaches to a voucher system, I would like to focus on one proposal that would form and important link between the current system and possible voucher proposals. It is the Medicare HMO payment proposal.

Millions of Medicare beneficiaries have been effectively denied the opportunity to become members of HMOs. Such membership can be a meaningful benefit. HMOs are organized health care delivery systems that provide coordinated care. Their physicians are able to guide the elderly through the often confusing maze of specialists and services necessary for their care. HMO benefit plans are generally comprehensive with no deductibles and only nominal copayments so that total health care costs are predictable and financial catastrophe because of acute health care costs is virtually impossible. In addition, the large amount of paperwork that burdens most Medicare beneficiaries does not exist in HMOs. Finally, the cost of an HMO for comparable benefits is generally less than the cost of fee-for-service care. This is largely attributable to appropriate hospital use.

When Medicare was enacted in 1965, it did not contain any provision to pay group practice prepayment plans (one of the HMO prototypes) on a basis consistent with the way they were paid for non-Medicare members. Instead, hospitals which served group practice prepayment plan members were paid under Part A on the same basis as other hospitals and such plans were paid for Part B services on a per capital basis which was cost-based. The only the other option was to submit bills and be paid on a fee-for-service basis.

In 1972, Congress added Section 1876 to Title 18 of the Social Security Act. This section provided for an improved method of payment for HMO's. It provided for a capitation payment for both Part A and B services on either a cost of risk basis and established the important principle that an HMO that chooses a risk contract would receive a portion of the savings (the difference between the average cost in the area for fee-for-service Medicare beneficiaries with similar characteristics to the HMO's members and the HMO's costs for its Medicare members).

This provision contains a number of publems. First, the final payment to the HMO is made retrospectively and may not be determined and paid to the HMO until two or three years after services are provided. This requires an HMO to finance the use of the savings if it uses them to reduce costs or add benefits for Medicare members, a risky and expensive provision. Second, Section 226(b) of Public Law 92-603 (the legislation which added Section 1876 to Title 18) provides that when an HMO enters into a risk agreement all its existing members must agree to obtain all their Medicare covered services through the HMO or terminate their membership. Under its general provisions, Medicare pays for the services received outside the HMO.

Making this change in coverage would be traumatic for many older persons. This is the major reason our Program and other HMOs with large Medicare memberships have not entered into Section 1876 risk contracts. We believe that requiring long-standing Medicare members of an HMO to limit their sources of services, or no longer belong to the HMO is unreasonable. Third, Section 1876 requires an HMO to offer one benefit package that covers only Medicare services. This excludes preventive and health maintenance services. This requirement is alien to the concept of health maintenance organizations and makes no sense. Finally, there is no requirement in Section 1876 about how HMO savings are to be used. Thus, HMOs need not pass on the savings to their members in the form of added benefits or reduced premiums.

Although there have been a number of prior efforts to change the way Medicare pays HMOs, it is especially important that a satisfactory method of payment be adopted at this time. During the past eight years, federal policy toward HMOs has been mixed, although Republican and Democratic administrations alike have strongly argued that the development of more HMOs would serve the public interest. Financial support has been provided under the HMO Act and pursuant to Section 1310 of the Act, millions of employees, mostly under the age of 65 have been offered membership in an HMO for the first time. On the other hand, existing methods by which Medicare pays HMOs are inadequate. They do not provide incentives for HMOs to enroll members or for Medicare beneficiaries to join HMOs. As a result, the number of Medicare beneficiaries to join HMOs. As a result, the number of Medicare beneficiaries enrolled in HMOs is small, and most Medicare enrollees belonged to the HMO before they became eligible for Medicare. The federal government will be terminating its financial support of HMOs. Consequently, we believe the adoption of a satisfactory Medicare HMO payment provision is imperative if Congress and the Administration, as they clearly seem to, favor the development of HMOs. Furthermore, enactment of such a proposal would provide the information and methodology needed to sucessfully implement a voucher system for all Medicare beneficiaries. This would include the data that can be used as the basis for making the adjustments in voucher amounts that will be necessary because of the difference in health care needs of medicare beneficiaries.

Medicare's current payment approach to HMOs would be reformed through H.R. 3399, a bill reported May 21, 1981, by the House Energy and Commerce Commitee. When the bill was introduced in the 97th Congress by Representatives Henry A. Waxman and Phillip Gramm, it was co-referred to the Energy and Commerce and Ways and Means Committees. A similar measure was reported by Ways and Means and passed by the House of Representatives in the 96th Congress. Under H.R. 3399, payments would be determined prospectively with no retrospective adjustments. An HMO would know in advance how much it would receive, could plan accordingly and would not have to finance the "savings." Existing Medicare members of an HMO would have the option of changing to the new program or remaining under the old one. It is important to note that in the Medicare demonstration project that Kaiser-Permanente is currently operating in Portland, Oregon, when this option was offered to 9,000 existing Medicare members, only 3,000 of them applied for the new program. HMOs would be required to pass their savings on to their members. This is an important requirement to assure that Medicare beneficiaries receive full benefits and to provide maximum incentives for them to join the HMO. Finally, an HMO would be able to develop benefit plans which covered preventive and health maintenance services and would not be required to offer a Medicare only benefit plan.

The proposal contains two new concepts: prospective average per capita costs and the adjusted community rate. These are necessary in order to determine the amount Medicare pays an HMO for each person enrolled and the amount that must be passed on to the Medicare members. When it was first introduced, there was considerable concern, especially among some Senate staff, about whether it was possible to develop prospective per capita costs and adjusted community rates. In addition, there was a serious question about whether Medicare beneficiaries would join an HMO.

In order to determine the answers to these questions, HCFA requested applications for demonstration projects and we submitted a proposal. The project has shown that it is possible to develop prospective average per capita costs. There are more than 300 rating categories in the rate book we use. They reflect differences in age, sex, disability status, institutional status, welfare status and geographical area.

The project, which we call Medicare Plus, has shown that the methodology for developing an adjusted community rate is available and workable. It is based on the existing Medicare method of paying HMOs on a cost basis with appropriate adjustments for utilization differences and time and complexity factors.

Finally, our demonstration project and the ones in Marshfield and Worcester have shown that Medicare beneficiaries will join HMOs. On May 23, 1980, Kaiser Foundation Health Plan of Oregon accepted the first application for enrollment under the HCFA demonstration with a plan to enroll 4,000 new Medicare members within the first six months. The membership goal of 4,000 was reached by October, 1980, so a decision was made in November to increase the total to 5,500 new Medicare beneficiaries. This new goal was achieved on January 1, 1981.

It is important to note that this new membership had about the same age and sex composition as the total Medicare population in the Portland area. We made a substantial effort to enroll a representative group of the Medicare beneficiaries in the community. These efforts included the unprecedented step for us of using media advertising to assure wide knowledge of the project among Medicare beneficiaries.

I will described briefly how the proposal works in Portland. In the Portland metropolitan area in 1981, it costs Medicare $119.13 a month, on average, for the medical care of Medicare beneficiaries with characteristics comparable to our new members who receive services in the traditional medical care delivery system. This monthly amount is the adjusted average per capita cost (AAPCC).

Under the demonstration, Kaiser Foundation Health Plan of Oregon (Health Plan) received 95 percent of the AAPCC, or $113.65. Thus, the federal government saved five percent at the outset. The beneficiary also is rewarded, an incentive that we believe is absolutely critical to attracting more elderly citizens to HMOs, by receiving benefits beyond the Medicare A and B package. These benefits include preventive services such as routine physical examinations, examinations for hearing, vision care and most immunizations, and elimination of deductible and copayment amounts, except for $2 copayment for office visits. They result from the requirements that the Health Plan pass along to its Medicare Plus members the difference between the AAPCC and its adjusted community rate.

The adjusted community rate (ACR) is the rate for providing the Medicare A and B benefit package to our Medicare Plus members. It is $94.60. Thus, the difference between 95 percent of the AAPCC ($113.65) and the ACR is $19.05. These "savings" pay for the benefits of Medicare Plus.

The savings also pay for a new service tailored specifically for Medicare Plus enrollees to facilitate their use of our health care delivery system. A new Medicare Plus Member Handbook was developed and written materials were mailed to new enrollees to obtain current health status information from them. This form was reviewed by a Permanente physician who determined which members needed to be contacted and scheduled immediately for a doctor's appointment.

We believe there are a number of provisions that should be included in any Medicare HMO payment proposal. First, HMOs should be required to enroll members without medical review. The only limitation on enrollment should be the capacity of the organization. This is the way we are enrolling in Portland. It eliminates favorable selection by the HMO.

Second, HMOs should be able to have their hospital bills processed by Medicare at their option as provided under existing law. This will assure that HMOs are not discriminated against in terms of hospital payments.

Third, the cost option for HMOs should be retained. New HMOs and those with small Medicare enrollments may be unable or unwilling to assume the risk involved.

Fourth, HMOs should be allowed to restrict enrollment to persons covered under both Parts A and B. This is what we are doing in Portland and it eliminates many adminstrative problems and confusion, especially at the beginning of a new program. Finally, an ongoing enrollment system should be established. At a minimum, as persons become eligible for Medicare, they should be advised of their right to enroll in any HMOs that are in the area and they should be informed of the benefits offered by such HMOs.

The Portland demonstration has validated some of the objectives of H.R. 3399. The demonstrations prove that if Medicare beneficiaries are rewarded for their willingness to enroll in organized, efficient health care delivery systems by sharing the savings with the Medicare program, they will do so. The consequences of more Medicare participation in HMOs are long-term cost savings for Medicare, more benefits for the elderly and creation of a more competitive health care delivery system. Competition is stimulated by offering Medicare beneficiaries a choice—the same choice that Congress now requires private employers to offer their employees.

We believe our demonstration program in Portland has shown that a rational system including prospective payment can be designed and implemented which will result in lower total costs for the Medicare Program and Medicare beneficiaries than could be achieved in the fee-for-service sector for comparable Medicare benefits.

We believe that H.R. 3399 is well balanced and will benefit HMOs, their Medicare members and the Medicare program. However, the bill has a larger importance than the significant improvement in the Medicare program it wil make and the benefits it will provide Medicare beneficiaries. H.R. 3399 is an important step in the efforts of the federal government to recognize cost effective health care delivery system. It will assist in their growth and development, make them more available to all Americans and is likely to have a beneficial impact on the cost of health care in the United States. It also will be a step toward the possible development of an effective Medicare voucher system. Now is a particularly appropriate time for Congress to make this significant reform, as it moves to recast federal HMO policy and encourage the development of competition in the health care industry.

Chairman JACOBS. Thank you, sir.

Mr. Gradison.

Mr. GRADISON. No questions.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. I have no questions.

Chairman JACOBS. We are grateful for the testimony which, of course, is part of the record.

Mr. Gephardt, do you have questions?

Mr. GEPHARDT. No.

Chairman JACOBS. Thank you very much, gentlemen. We are most grateful.

Is Dr. Wurtz present? If so, please come forward, Dr. Keith Wurtz.

We will call a panel now of the American Nurses' Association, the National Federation of Licensed Practical Nurses and the American College of Nurse-Midwives, Prof. Claire Fagin, Paul M. Tendler and Ms. Sally Tom.

Would you begin the testimony, please? You are all aware of the 5-minute rule, I suppose. You will hear an egg timer when 5 minutes is up. The shortest testimony of the day gets the reward at the end of the day. We won't ask the shorthand reporter to pitch into that pot. Proceed.

STATEMENT OF CLAIRE FAGIN, PH, D., R.N., DEAN, SCHOOL OF NURSING, UNIVERSITY OF PENNSYLVANIA, ON BEHALF OF THE AMERICAN NURSES' ASSOCIATION, ACCOMPANIED BY TOM NICKELS, LEGISLATIVE COUNSEL

Ms. FAGIN. I am Claire Fagin, dean of the Pennsylvania School of Nursing, also a member of the private sector task force advising the Secretary of Health and Human Services on competitive health plans.

I am testifying today on behalf of the 170,000 members of the American Nurses' Association, the national professional association of registered nurses.

With me is Tom Nickels, legislative counsel of ANA. In this testimony we want to express our support for many of the underlying concepts of competition reform. However, we do have some concerns about some aspects of the proposals and offer some suggestions on how the competitive model can be made more responsive to the health care needs of this Nation.

Historically, the American Nurses' Association has supported the concept of a comprehensive national health insurance system and believes that any program must recognize the need for change in the present costly system.

It should break away from reliance on expensive institutionalization. It should encourage better utilization of all health care personnel and it should modify current reimbursement procedures. It should be recognized that these three caveats will lead to cost reductions in the total system.

We believe the Federal Government must require minimum benefit package including preventive, maintenance, diagnostic treatment, and protective services. The inclusion of ambulatory preventive and maintenance health services is critical to the improvement of the Nation's health status. These services are essential if we are to move away from our emphasis on acute and chronic care in the most expensive health care settings we have in this country.

Under any competitive plan registered nurses should be recognized as health care providers in ambulatory settings and nursing services should be included as a covered benefit. Nursing services in hospitals should be separated from routine inpatient operating costs.

This would provide consumers a more accurate picture of what they are paying for, encourage hospitals to better discriminate among needed services and act as a stimulus to greater accountability among the providers.

In short, consumers would become more aware of the nature of services being purchased with the health care dollar.

We also believe that any competitive program should provide coverage to all Americans regardless of economic circumstances. We are concerned that failure to mandate employer coverage of health insurance may mean that even fewer Americans will qualify for plans. A voluntary plan will do nothing for those not presently covered and will not guarantee that those who are employed will be covered.

All of the competitive proposals would distribute the burden of restraining costs among the consumer, the provider, and the health planner.

We agree that consumers are shielded from the true financial costs of their decisions. However, we believe that the proposals places an unfair burden on the consumer who may lack essential information and expertise about health care services as well as appropriate access to alternate and more cost-effective services and providers.

Both the demand and supply in the health care market are controlled by those who provide the services, not those who utilize them. Better than 70 percent of all health care decisions are made by physicians, not consumers, especially regarding such critical decisions as hospitalization, prescription of drugs and ordering of lab tests. There is nothing in the current proposals which insures that these conditions will change.

Health care is not like other goods which are bought and sold in the marketplace. Therefore, legislation must include provisions for consumer education. A stipulation requiring all those who market qualified health plans to fund increased consumer education would be a positive beginning.

Another area in which we have concern is that regarding the proposed use of vouchers by medicare and medicaid beneficiaries. In our opinion, use of vouchers would be plagued by lack of consumer information regarding health care. The already existing evidence from the medigap experience suggests that these proposals as presently constituted would not be in the best interest of our most vulnerable citizens.

Promotion of competition among providers, both professional and organized service providers, must serve as the cornerstone of any legislative proposal to reduce costs and encourage the operation of a free market.

The current health care system focuses on illness, acute care and medical services and neglects to address the issue of long-term care as well as proposals for alternate modes of care which have been shown to have cost benefits.

Qualified health plans must offer direct access to appropriate health services and professional providers. Plans should be designed to make full use of competencies of a variety of health care providers and of different types of health services.

Professional nursing services and professional nurse providers must be identified within the health care system and within qualified health plans.

It has been shown that a variety of predominantly nursing interventions have low-cost and high-benefit results and a large amount of data presently exists on this subject. Nursing services and acute care, chronic care and preventive care, can contribute immeasurably to the goals of a competitive delivery system.

Many barriers exist which prevent the consumer from choosing nursing services and the services of other professional providers of health care. We are pleased that H.R. 850 addresses the need to remove restraints from access to appropriate health services. None of the proposals under consideration adequately addresses the issue of quality assurance. That is serious omission.

The Government must continue to play a role in assuring that the highest quality services are provided through health plans. The assurance of consumer safety in health care services cannot be left to the mercy of the free market system's ability to flush out inadequate and substandard health care.

Thank you for the opportunity to appear here today. We realize that the concept of a competitive health care system is in its formative stage. We believe nurses play a pivotal role in future developments and stand ready to work with the committee in the continued formulation of this concept.

[The prepared statement follows:]

STATEMENT OF DR. CLAIRE FAGIN, DEAN, SCHOOL OF NURSING, UNIVERSITY OF PENNSYLVANIA, ON BEHALF OF THE AMERICAN NURSES' ASSOCIATION

INTRODUCTION

Mr. Chairman, I am Dr. Claire Fagin, Dean of the University of Pennsylvania School of Nursing. I am also a member of the private sector task force currently advising the Secretary of Health and Human Services on competitive health plans. I am testifying today on behalf of the 170,000 members of the American Nurses' Association, the national professional association of registered nurses.

For many years, the American Nurses' Association has recognized health care as a basic human right. ANA actively supported the extension of the social security system to include health insurance for the aged (Medicare). ANA has long promoted the inclusion of nursing services as covered health benefits, and has argued that registered nurses should be recognized as providers of care—and be reimbursed for services rendered. In addition, ANA has considered prepayment insurance systems to be an effective way to deliver a comprehensive range of health care services.

ANA believes that some form of national health program is essential if this nation is to ensure that its citizens are to have access to a comprehensive range of health services of an acceptable quality. Such a program must recognize the need for change in the present costly system. It should modify current reimbursement procedures. It should break away from reliance on expensive institutionalization. It should encourage better utilization of all health care personnel—including registered nurses.

Discussion of health care goals in the 97th Congress has focused on the concept of competition in the health care system. The American Nurses' Association is therefore reexamining its historic posture in support of a comprehensive national health insurance system in light of this new focus. In this testimony, we want to express both our support and concerns regarding competition, and to offer some suggestions as to how the competitive model can be made more responsive to the health care needs of this nation.

At the outset, we would agree with the two basic tenets at the foundation of the competitive approach: first, that health care costs have risen at an unacceptably high rate and must be contained; and second, that there is an appalling lack of competition in the health care market.

Several proposals have been introduced in the 97th Congress to stimulate competition in the financing and delivery of health care. These proposals retreat from a national focus on regulatory cost containment to a greater reliance on market incentives to contain costs. The bills encompass the following basic concepts: increased cost-sharing by consumers of health care through copayments and deductibles; a fixed maximum employer contribution to employee health plans uniformly offered to all employees; the inclusion in taxable income of all premium payments above the maximum limit; and rebates to those employees choosing a health plan less costly than the maximum contribution. In addition, HR 850 would establish a voucher system so that Medicare beneficiaries could participate in the buying of health plans.

MINIMUM BENEFIT PACKAGE

In our opinion, the federal government must require a basic level of benefits to ensure that the standard of health care in this country does not actually decrease because of the passage of a competitive bill.

This minimum benefit package should include a range of health services, including preventive, maintenance, diagnostic, treatment and protective services. Essential service should include in-patient, out-patient, 24-hour emergency care, home care, clinic services, rehabilitative care, preventive and supportive care (teaching, counseling and health education, maintenance care).

The inclusion of preventive health services is critical to the improvement of the nation's health status. Our current health care system focuses on trying to cure people after they become ill. It relies on the most expensive health care setting, the hospital, and the most expensive health care practitioner, the physician. Care of the aged is still focused in the nursing home. Access to preventive care can eliminate the need for acute care later, resulting in tremendous savings in terms of human suffering as well as dollars. We support the provisions of S. 139 which require employers of fifty or more persons to provide preventive services. We would like to see this coverage extended to all persons.

Under any competitive plan, professional registered nurses should be recognized as health care providers and nursing care services should be included as a covered benefit. We note that none of the bills introduced has done so. Patients are hospitalized so that they can receive continuous nursing service. Current proposals continue to lump nursing services under the nebulous rubric of "routine, impatient operating cost." This category also includes activities such as housekeeping, laundry, and maintenance services. Separation of the professional nursing component from routine operating costs would provide a more accurate picture of the patient's need for continuous nursing care, and act as a better barometer of health care costs. We believe such a change would benefit most those paying for nursing services. Consumers would become more aware of the nature of services that they are buying with their health care dollar.

ELIGIBILITY

In spite of our enormously expensive health care system, there are many persons who are denied access to services. By conservative estimates, at least 20 million Americans have no health insurance coverage, and another 20 million have inadequate coverage. We believe that any competitive program adopted should provide coverage to all Americans, regardless of economic circumstances. None of the current legislative proposals envisions expanded coverage for the poor and aged.

By failing to mandate employer coverage of health insurance, we are concerned that even fewer Americans will qualify for plans. A voluntary plan will do nothing for those not presently covered, and will not guarantee that those employed will be covered. It is possible that competition could actually increase the pool of people currently faced with inadequate health insurance.

Even those who will continue to be eligible for health care services may receive reduced benefits because of the use of large copayments and deductibles. Several studies show that increased use of deductibles and copayments can create financial barriers which deter early access to treatment, especially preventive care. This ultimately results in the utilization of more costly acute care, and costs more money than it saves. When California required co-payments for physician visits, physician use immediately declined 8 percent, but inpatient hospital use suddenly increased by 17 percent. Patients unable to afford the co-payment delayed seeing a physician until they became so ill that they required hospitalization. We can see proposals for large co-payment and deductibles aggravating this already unacceptable situation.

As a registered labor organization, the American Nurses' Association is concerned that the competitive proposals will have a negative impact on health benefits negotiated through the collective bargaining process. Organized labor has been at the forefront of the movement to eliminate barriers to early access to preventive services, and to secure comprehensive health coverage. These advances may be threatened by the competitive model. We are encouraged that HR 850 does provide for existing contracts to be grandfathered into a system until the annually adjusted exclusion limit surpasses the employer's existing contribution.

CONSUMERS

All of the competitive proposals would distribute the burden of restraining costs among the consumer, the provider, and the health plan. The cosumer is presently insulated from the true cost of health care because of third party payment of claims. Consumers have little or no financial incentive to question the need for or value of services, and receive no regard for the utilization of more cost-efficient providers. Thus, competition looks to create cost conscious consumers through tax incentives and cost-sharing.

While agreeing that consumers are shielded from the true financial consequences of their decisions, we question both the logic and fairness of placing an unfair burden of containing health care costs on the shoulders of the consumer. This seems unwise and unwarranted for several reasons. First, it is well established that both the demand and supply side of the health care market are controlled by those who provide the services, not those who utilize the services. Furthermore, the providers set the prices. Better than 70 percent of all health care decisions are made by the physician, not the consumer, especially regarding such critical decisions as hospitalization, prescription of drugs, and ordering of lab tests. Second, the consumer often lacks the critical knowledge as to what kind of treatment is necessary and appropriate. Health care is a complex matter involving knowledge that can only be accumulated through years of study. Consumers lack essential information and expertise about health care services. Finally, to ask consumers to make rational decisions, particularly in life-threatening situations or when they are acutely ill, seems both unfair to the patient, and an inappropriate cornerstone for national health policy. Consumers cannot anticipate when they will be ill, and have few choices to make about health care services when they need them.

It is our observation, therefore, that current competition proposals are not in the best interest of the consumers of health care. Health care is not like other goods which are bought and sold in the marketplace. Legislation must include provisions for consumer education. A stipulation requiring all those who market qualified health plans to fund increased consumer education would be a positive beginning.

VOUCHERS

We have concerns regarding the use of vouchers by Medicare and Medicaid beneficiaries, as envisioned by H.R. 850. The American Nurses' Association has long been dedicated to the provision of adequate long-term care services to our aged population. We regret that the competitive proposals do not address the issue of long-term care, unquestionably one of the largest expenses, and most frightening experiences, faced by the elderly in this country.

In our opinion, the use of vouchers will be plagued by the lack of consumer information regarding health care, which can only be exacerbated for the elderly, who would become even more confused by the difficult and complex choices required by the competitive proposals. The imposition of increased co-payments and deductibles seems particularly unfair for the elderly, many of whom survive on fixed incomes. In addition, we are concerned that the high incidence of fraud and abuse surrounding the Medigap scandals may be repeated under the competitive plans. As our more vulnerable population, least able to afford increases in out-of-pocket expenditures for health care, we believe that the use of vouchers would not be in the best interest of our elderly citizens. The concept needs careful scrutiny.

COMPETITION AMONG PROVIDERS

Promotion of competition among providers, both professional and organized service providers, must serve as the cornerstone of any legislative proposal seeking to reduce costs and encourage the operation of a free market.

The current health care system focuses on illness and acute care i.e., medical services. It encourages the consumer to seek services after illness is apparent and to receive treatment in costly inpatient settings.

Qualified health plans must offer access to other health services and professional providers. Furthermore, plans should be designed to make full use of the competencies of a variety of health care providers and of different types of health services.

Professional nursing services and professional nurse providers must be identified as significant providers of health care services within the qualified health plan. It has been shown that a variety of predominantly nursing interventions have low cost/high benefit results. Such studies show that nursing services contribute immeasurably to the goals of a competitive delivery system.

Studies comparing the quality of nurse midwifery with routine obsterical care delivered by obstetrical residents show major reductions in prematurity and neonatal mortality, decreases in percent of low birth weight babies, and increases in the number of babies born symptom free. Nurse rehabilitators at Baltimore City hospitals, working with patients who had myocardial infarctions, were shown to be effective, at minimal cost, in increasing return to work, improving patient knowledge, and decreasing smoking. Chronically ill patients at the Loeb Center for Nursing and Rehabilitation at Montefiore Hospital scored higher on assessment of functional status, experienced fewer hospitalizations and nursing home admissions, and incurred significantly lower overall costs than patients receiving traditional care at the hospital. There are numerous examples which demonstrate the high quality or care provided by nurses at a cost lower or equal to costs for currently reimbursable services.

Many barriers exists which prevents the consumer from choosing nursing services and the services of other professional providers of health care. This lack of choice stems from two areas: exclusion of nonphysician providers from practice in certain settings; and refusal by third party payors to reimburse providers other than physicians. We are pleased that H.R. 850 addresses the need to remove restraints from access to appropriate health services. We support section 302(b)(2) which would preempt any law, regulation, or administrative action of any state or local government that prevents or impedes the reforms of the health care system contemplated in the bill, including laws dealing with the licensing of health care personnel that have no direct bearing on professional quality or laws creating undue statutory leverage for certain professional groups.

QUALITY OF CARE

The free market environment must not be used to ration essential health care or to provide inferior care in order to achieve cost effectiveness. Standards of care must be developed collaboratively by those professionals engaged in clinical practice, and peer review mechanisms should be put in place within each health care discipline. The government must continue to play a role in assuring that the highest quality services are provided through all health plans.

None of the legislative proposals under consideration adequately address the issue of quality assurance. The assurance of consumer safety in health care services cannot be left to the mercy of the free market system's ability to flush out inadequate and substandard health care services.

CONCLUSION

In conclusion, we believe that reform of the health care delivery system is long overdue. Competitive health models must protect the several dimensions of access to care including (1) the availability of services in the community; (2) ability to obtain services by any and all sub-groups of the population; and (3) comprehensiveness of services offered either by the source of first contact care or facilities linked with it. We are aware that the concept of a competitive health care system is in its formation stage. We have expressed our concern about some of the major problems evident in the model, as well as our concern about those needs the model does not address. The American Nurses' Association is willing to work with the committee in the continued formulation of this concept. We thank you for allowing us to appear here today.

Chairman **Jacobs**. Thank you, Doctor and Nurse Fagin.

STATEMENT OF PAUL M. TENDLER, LEGISLATIVE CONSULTANT, NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

Mr. **Tendler**. Thank you, Mr. Chairman. My name is Paul Tendler, legislative consultant to the National Federation of Licensed Practical Nurses, and I am an adjunct professor at Georgetown University.

For some time now there has been a debate regarding the need to lower the cost of health care. Happily we have progressed to the point where it no longer focuses on whether or not we should, but rather how shall we do it.

While much discussion has ensued over the years, the present bills now being considered by the Congress provide only a framework for discussions, and efforts must be made to consult with providers and consumers in an attempt to establish a workable and worthwhile program.

Your efforts to reach as many people as possible with hearings such as this are important and should be recognized as a major step in bringing us closer to a solution to this problem.

Because this matter is so important, it is imperative that you carefully consider the views and recommendations of the widest possible sources of individuals and groups and weigh their professional judgments. Our views are based on our experience, observations and expertise as health care providers.

As such we have serious reservations regarding the workability, efficiency, accessibility, and equity of these competition bills. It is for this reason that the National Federation of Licensed Practical Nurses, which is comprised exclusively of LPN's appreciates this opportunity to share with you its views and recommendations regarding legislation which would stimulate competition in health care delivery.

The 600,000 members of the practical nursing profession are an integral part of the health care team. Nurses are the largest group of health providers in the country, and play a vital role in the delivery of health care services. Because of their skills and educational preparation, they have been professionally prepared to serve whenever and wherever necessary.

The National Federation of Licensed Practical Nurses adopted a resolution regarding health care delivery at its annual convention in 1977. The resolution, which addresses the basic concepts of a health care delivery program, includes the practical nursing profession's recommendations on coverage, benefits, financing, administration, and utilization.

We find that our present system of health care is not only grossly inadequate and severely deficient but extremely costly. This is due partly to fragmentation of services, as well as uncoordinated and incomplete benefits.

As a result of this inefficiency and inadequacy, we see that in the 10-year period between 1965–75, national health care expenditures have tripled and that in 1980, total costs reached $52 billion. High costs of essential health care services prohibit and hinder the delivery of health care to large numbers of people, both young and old, especially in the inner cities and rural areas of the country.

Because of this, it is estimated that 15 percent of the adult population suffer from undiagnosed hypertension and many people will die needlessly of cancer.

Of the services now provided both through private and governmental insurance plans, we note that most children in the United States will not see a dentist this year, and many elderly will not be able to afford needed medication or an extended care facility.

What is even more distressing is that at least 40 million Americans have no health insurance coverage whatsoever and that 25 percent of the population under 65 years of age are not protected from the spiraling costs of hospital and surgical services.

Home health care for nearly 1½ million disabled Americans is almost impossible. Preventive health care, which could save an estimated $25 billion a year because the need for costly hospital stays and surgery would be drastically reduced, is unavailable.

It is for these reasons, and many more too numerous to mention, that we believe a competitive health program should be adopted which has the following characteristics:

One. Universal coverage;

Two. Comprehensive benefits;

Three. Clearly identified and widely disseminated benefits;

Four. Full utilization of all health care providers;

Five. Nursing care should be a direct benefit and distinct service of a competent health insurance program;

Six. Practical nursing should be included in a nursing care program;

Seven. Licensed practical nurses should be designated as providers;

Eight. It should insist on State licensure as opposed to Federal or national licensure;

Nine. Peer review system which will assure health care quality and protect the rights and the responsibilities of each health care discipline;

Ten. Consumers should participate in periodic evaluation;

Eleven. Privacy of the individual's personal health data must be preserved.

UNIVERSAL COVERAGE

Individual health care is a basic human right, and comprehensive health services should be accessible, available, and acceptable to all people regardless of their age, sex, race, social, or economic status.

It means that coverage for individuals must not be tied to a payroll tax unless provisions are provided for the unemployed or seasonally employed individual.

COMPREHENSIVE BENEFITS

Comprehensive health services should include a total range of physical, mental, and social health care services which shall include, but not be limited to, preventive, diagnostic, therapeutic, restorative, or maintenance services.

National health insurance must specifically differentiate between "health" and "medical" services and be sure both are included. Comprehensive health services should also include catastrophic illnesses.

Services should not be limited to a per-day basis but should be provided on a medical or health need basis. To do otherwise would be too costly in the long-range effect and would be less than comprehensive.

Essential services should include inpatient and outpatient care, partial care round-the-clock emergency care, rehabilitative care, preventive and supportive care—teaching and counseling—and maintenance care.

Inpatient care should provide for acute and long-term care and all other essential and necessary services.

Outpatient care should include services such as home services, clinics, physicians offices, health centers, schools, and industry. They should also include diagnostic-screening, such as laboratory fees and X-rays, psychological testing, physical and mental assessments, and social services.

Similarly, therapeutic treatment such as prescribed drugs, psychiatric services, pre- and post-natal care, equipment and supplies through home health services including prosthetics, dentures, eyeglasses, and hearing aids, should be included.

Rehabilitative services should be all the services necessary to assist persons to function at their maximum level.

Maintenance services should be those required to keep a person functioning at their highest level.

All of these services should be closely coordinated with community planning so essential social services, such as transportation and meals on wheels, can function together.

In describing these services, the services which can be done by the nursing profession, RN's and LPN's, should be clearly identified, and such words as physician assistants, physician extenders, and nurses should not be used interchangeably. When nursing is defined, it should specifically include RN's and LPN's.

CLEARLY IDENTIFIED BENEFITS AND LIMITATIONS

All benefits should be the same to all people, regardless of age, sex, race, national origin, social, or economic status. Benefits should not be based on income and all services should be available to all people. Any limitations to coverage should be limited to all people and clearly spelled out.

Providers should be made aware of what services they can provide as a benefit. Coverage and limitation should be disseminated to all people, providers and consumers alike, and a deliberate effort should be made to disseminate this information.

FULL UTILIZATION OF HEALTH CARE PROVIDERS

To assure that we are effectively using the Nation's health manpower to its fullest extent, there should be a clear definition of the terms "health" and "medical" care.

Health care providers must be able to function at their maximum level commensurate with their level of educational preparation.

The term "nursing care" should be used to refer to services provided by nurses, and licensed practical nurses should be identified separate and apart from nurses' aides or nursing assistants.

NURSING CARE SHOULD BE A DIRECT BENEFIT AND A DISTINCT SERVICE OF A NATIONAL HEALTH INSURANCE PROGRAM

Nursing care should be distinctly identified as a benefit in the national health insurance program. Nurses [RN's and LPN's] should be identified specifically as providers, and the settings in which LPN's and RN's work should have a mechanism which would provide for reimbursement.

These settings should include, but not be limited to, institutional care, community care, home care, intermediate and long-term care facilities.

PRACTICAL NURSING SHOULD BE INCLUDED IN A NURSING CARE PROGRAM

For years now, LPN's have played a major role in the delivery of health care services, especially in a home health care setting. Their professional position within the health care delivery team makes LPN's uniquely qualified to fill the gap between the professional registered nurse and the nurse's aide. Not only can an LPN provide much of the same skilled care as a registered nurse or, in some instances, a physician, but the LPN can do it at a much lower cost.

Remember it is the LPN to whom millions of Americans turn to find help when RN services are not needed or are too costly and when the educational preparation and skill of nurses' aides or homemakers are inadequate.

LICENSED PRACTICAL NURSES SHOULD BE DESIGNATED AS PROVIDERS

In recent years, the Congress has recognized the need for a more multilevel and multidisciplined utilization approach which could use the skills of RN's and physician extenders. We believe that the system could be expanded even further.

Health providers, such as LPN's, could deliver more effective and complete services if they were made part of the delivery system as designaged providers, eligible for reimbursement.

Millions of Americans would have significantly better care because there would be greater emphasis on preventive care and greater access to the delivery system.

STATE LICENSURE

It is the belief of the National Federation of Licensed Practical Nurses that the individual licensure of health care practitioners is best administered by the States.

National licensure, besides being of questionable constitutionality, is cumbersome and unnecessary. Institutional licensure would be too restrictive. The present system whereby national examinations are administered by the State through the State boards of nursing functions well. It presents geographical mobility, yet preserves the high quality of licensed practitioner that the public deserves.

PEER REVIEW

We endorse the concept of peer review because we believe that each practitioner should be accountable for his or her own professional actions and that only a practitioner actually engaged in that aspect of health care delivery is qualified to effectively evaluate the necessity, appropriateness and quality of nursing care.

Because of this belief, we suggest that this principle be extended so that licensed practical nurses be included in any such review process because, like professional registered nurses, they, too, have the unique experience and educational background to evaluate the necessity, appropriateness and quality of practical nursing.

We believe that professional accountability will better serve health care consumers. Our members are proud of their profession and take great pride in their performance as health care providers.

One of the prime responsibilities of peer review is to assure that health care is being provided within the bounds of sound professional standards. Yet these very standards can only be as sound as the judgment of those conducting the review and rendering the evaluation. Some have assumed that anyone possessing a degree in medicine is qualified automatically to define and judge the quality of the services done by health care providers.

The National Federation of Licensed Practical Nurses strongly disagrees with that assumption. We contend that the performance of any given health provider can best be judged by one who possesses expertise and firsthand knowledge and experience of the work which that profession performs. In other words, peer review is the strongest, most reliable foundation for evaluation.

We believe that other professionals can offer valuable contributions to an overall review. They can. They do. But physicians alone do not make up the whole fabric of our health care system. Rather, it is made up of the threads of many health professionals and support groups, some of whom have no direct connection with one another beyond the fact that they are parts of the whole.

In this way, a physician may know something of a licensed practical nurse's work or a licensed practical nurse of a physician's, but neither may know the entire scope of the other's duties, priorities or practice.

It is more than job enough for each to carry out his or her own responsibilities without becoming an instant expert on another's profession.

For this reason, we believe it is unfair to bestow on any one group of health care providers the power of judgment on all others. Instead, we would like to see that responsibility and power shared by a coordinated group of professionals dedicated to providing the quality health care Americans demand and deserve.

In this regard, we wish to point out two basic reasons why LPN's should be included in any peer review program regarding the present status of health care providers.

First, no one discipline in health care has the expertise and skill to operate independently of another. To do so would be inefficient and detrimental to the comprehensive care of the patient.

Second, likewise, there are different levels of nursing. Practitioners in each level are specially prepared to function at a level commensurate with their educational background.

To exclude one level of nurse from participating in all of the activities of peer review would be just as improper as limiting peer review to one profession. No one group of practitioners or one professional association can speak for or evaluate another's practices.

Peer review is designed as a solution to the problem of rising cost and high incidence of medically inappropriate services rendered to patients.

We oppose the recent budget cuts in this area.

CONSUMERS SHOULD PARTICIPATE IN PERIODIC EVALUATION

We join with you in exploring as many alternatives within a national health insurance program as possible to assure the most suitable health care for Americans.

Whatever national health insurance program evolves, it must be remembered that the program is for the consumer, and it must be responsive, effective and compatible with his needs.

The consumer must not only have access to the decisionmaking process, but must in fact be part of it. Mechanisms for review and action on programs which are ineffective or on abuses within the system must be accessible to the consumer.

PRIVACY OF THE INDIVIDUAL'S PERSONAL HEALTH DATA MUST BE PRESERVED

Statistics may be kept to keep track of an individual's health, for planning, managing, and evaluating and to determine health care resources. However, data gathering must not be secret, and there must be a mechanism where a patient can find his health record and correct errors. Health data should be used for study and research only.

The National Federation of Licensed Practical Nurses recognizes the need to reduce health care costs but not the quality, availability, and accessibility of health care itself.

The present bills before the Congress should consider the need to provide comprehensive benefits where needed and that all health providers share in the delivery of services.

Our concern rests with the content and quality of health care programs.

It is for this reason that we are submitting to you along with this testimony the resolution on health care delivery which the National Federation of Licensed Practical Nurses adopted in 1977.

Our tasks are enormous, but our goals are laudable. If we are to continue to flourish as a Nation, we must treat our ill and infirm as we would treat our strong. For a strong Nation which cannot care for its weak soon becomes too weak to care for its strong.

Thank you, Mr. Chairman.

[An attachment to the oral statement follows:]

STATEMENT OF NATIONAL FEDERATION OF LICENSED PRACTICAL NURSES, INC.

A. The National Federation of Licensed Practical Nurses believes that health care is a basic human right, and, therefore, supports the concept that there be a national system of health insurance benefits which would guarantee comprehensive health and medical services accessible, available and acceptable to all people without regard to age, sex, race, social or economic status.

1. Comprehensive health services shall mean the total range of physical, mental and social health care services which shall include but not be limited to preventive, diagnostic, therapeutic, restorative or maintenance services.
2. Comprehensive health services shall also be extended to include catastrophic illnesses.

B. A national health insurance program shall include provisions for the utilization of all health care providers.

1. Nursing care is a distinct service which is an integral part of any comprehensive health care system and should be included as a program benefit.

C. Through the mechanism of organized nursing services provisions should be made for the utilization of Registered Nurses and Licensed Practical Nurses in all health care settings.

These settings should include but not be limited to in-patient, out-patient, ambulatory and home health care.

D. Practical nursing services are integrated in the nursing care process.

Licensed Practical Nurses should be specifically designated as health care providers in any national health insurance program.

E. The benefits of any national health insurance program and any limitations and/or qualifications for receiving such benefits should be clearly identified, widely disseminated and easily understood by providers and beneficiaries alike.

F. Any national health insurance program should provide protection of the rights and privacy of individuals in their data systems necessary for effective management.

G. For the purposes of credentialing, the National Federation of Licensed Practical Nurses recommends the continuation of the system of individual licensure for the practice of nursing.

H. Any national health insurance program should make provisions for consumer participation in periodic evaluation of the national health insurance program.

I. Any national health insurance program should make provision for peer review of services that will protect the right and the responsibility of each health care discipline to monitor the practice of its own practitioners.

J. NFLPN strongly urges the designation of Licensed Practical Nurses as health care providers, in any pending or proposed legislation on national health insurance.

STATEMENT OF SALLY TOM, GOVERNMENT LIAISON, AMERICAN COLLEGE OF NURSE-MIDWIVES

Ms. Tom. Hi, good morning. My name is Sally Tom. I am a practicing certified nurse-midwife, representing the American College of Nurse-Midwives.

I am very pleased to have this opportunity to meet with you today and I apologize for being late.

The American College of Nurse-Midwives [ACNM] is the professional organization of certified nurse-midwives [CNM's] in the United States, representing 85 percent of all CNM's.

The ACNM is autonomous from all other professional organizations and speaks for its membership on all issues affecting the practice, education, recognition, legislation, and economics of nurse-midwifery.

The ACNM collaborates with other professional groups which share its primary concern of quality maternal and infant health care for women and babies and is recognized as an advocate for maternal and child health care issues.

According to the official ACNM definition, "A certified nurse-midwife is an individual educated in the two disciplines of nursing and midwifery, who possesses evidence of certification according to the requirements of the American College of Nurse-Midwives."

Nurse-midwivery practice is the independent management of care of essentially normal newborns and women, antepartially, intrapartially, postpartially and/or gynecologically.

This occurs within a health care system which provides for medical consultation, collaborative management, and referral and is in accord with the functions, standards and qualifications for nurse-midwifery practice as defined by the ACNM.

There are approximately 2,400 nurse-midwives in the United States and approximately 220 more graduate each year. Most nurse-midwives practice in association with institutions such as hospitals, clinics, and birthing centers. A small number offer home birth services. In 1976–77, nurse-midwives did approximately 1 percent of all births in the United States.

I want to talk with you today about nurse-midwifery care, about the obstetrical market and about competition among health care providers.

Nurse-midwifery care has been shown to be safe. Infant mortality rates drop significantly when nurse-midwives are introduced into poor communities. Professional midwives give the major part of the obstetrical care in developed countries which have lower infant mortality rates than our own.

All available research shows that women having healthy pregnancies have just as good or better outcomes with nurse-midwives as with physicians.

Nurse-midwives give cost-effective care. Individual women and insurance companies benefit from the characteristics of nurse-midwifery care which lead to lower costs. These include lower Cesarean section rates, use of birth settings outside of hospitals, early discharge plans and individualized, rather than routine use of expensive technology.

Dr. Ruth Lubic, C.N.M., director of New York's Childbearing Center, estimates that a billion dollars could be saved in our health care system if birth centers modeled after the childbearing center were more widely available.

Lowered infant mortality rates mean lowered costs to insurance plans for intensive care nurseries. Positive birth experiences undoubtedly contribute to better relationships between parents and children and to lower rates of child abuse and neglect. Thus, nurse-midwives save society both emotional and financial resources.

At the December 1980 congressional hearing on restraint of nurse-midwives' trade held by the Energy and Commerce Committee, Dr. C. Arden Miller, chairman of the Department of Maternal and Child Health of the University of North Carolina said:

> If one looks for reasons why this country is deprived in many areas of the services of midwives, one has to look in the political and economic arenas.

Nurse-midwives have been taking care of low-income women in this country since 1925, but always as employees of health departments, physicians and Federal or State governments.

In the last decade, in part because Federal programs made nurse-midwives visible in many communities, affluent women began seeking nurse-midwifery care. Nurse-midwives have responded to these consumers by entering the private sector.

A few nurse-midwives now are financial partners with physicians and some are self-employed. These self-employed nurse-midwives hire physicians to provide medical consultation, collaborative management and referral for women who develop medical complications.

The economic relationship between nurse-midwives and physicians is changing, but the clinical relationship remains the same. The client of a nurse-midwife always has access to a physician when she needs one.

Increased consumer demand has led some private insurance companies to reimburse nurse-midwives directly and has moved Congress to reimburse nurse-midwives through the civilian health and medical plan of the uniformed services [CHAMPUS] and medicaid.

The obstetrical market has several features which make it unique in the health care industry. There are three major procompetitive forces in the obstetrical market. First, many types of health care providers offer the same core of obstetrical services to consumers. Women and their families can choose from among obstetricians, general practice physicians and certified nurse-midwives.

Second, most childbearing women are healthy people. Their needs are vastly different from those of people who are sick and who need a health care system which concentrates on and specializes in illness care.

Third, the availability of a variety of providers does not artificially stimulate a demand for services. Women will be having pregnancies whether or not several kinds of providers are available to them. Directly reimbursing both physicians and certified nurse-midwives does not artificially inflate costs.

There are three major anticompetitive forces in the obstetrical market. The overall impact of these forces is to reduce the ability of the various types of providers to compete with each other. This impact shows up most dramatically in the relationship between certified nurse-midwives and physicians.

First, large segments of the health insurance industry, including Blue Cross and Blue Shield, still do not directly reimburse nurse-midwives. The lack of reimbursement limits consumers' ability to choose nurse-midwifery care.

Second, malpractice insurance companies have the power to determine who can practice and how that person can practice. Malpractice insurance companies have restrained the trade of certified nurse-midwives and of physicians who work with nurse-midwives.

Third, resistance to nurse-midwifery practices from physicians is strong and appears to be growing. This resistance comes from organized groups of physicians and individual physicians, it takes many forms and is found across the country.

In closing, the ACNM would like to make several recommendations to the Congress.

One. The Congress should use its regulatory power to increase the ability of nurse-midwives to compete effectively with physicians in the obstetrical market.

Two. The Congress should design reimbursement systems which tap the procompetitive features of the obstestrical market, such as reimbursing low technology health care and various types of primary health care providers.

Three. The Congress should investigate the anticompetitive practices of the malpractice insurance industry.

Four. The Congress should pass legislation which provides for direct reimbursement of certified nurse-midwives in all Federal health plans which offer well-woman gynecological care and obstetrical care.

The American College of Nurse-Midwives is very pleased to have been invited to testify on the issue of competition in health care. The members look forward to working with you in your efforts to provide high quality care to women and childbearing families.

I want to refer you to the information which is appended to this testimony for an indepth analysis of the safety, cost-effectiveness and political struggles of nurse-midwives.

Thank you.

[The attachments to the statement follow:]

THE SAFETY OF NURSE-MIDWIFERY PRACTICE

The safety of nurse-midwifery care has been well established. At a hearing held December 18, 1980, by the Subcommittee on Oversight and Investigation of the Interstate and Foreign Commerce Committee, noted epidemiologist, C. Arden Miller said, "All of the studies I know confirm that the health benefits of care as rendered by nurse-midwives stand up to scientific scrutiny exceedingly well." He added that many of the interventions routinely used in obstetrics today have been subject to a scientific scrutiny which ". . . is in many respects less rigorous than the scrutiny to which the midwife's services are subjected." [1] A considerable body of research documents the safety of nurse-midwifery care. All studies have shown that the risk to women attended by nurse-midwives is equal to or lower than the risk to comparable groups of women attended by physicians. In fact, the literature reports instances of striking reductions in infant mortality rates after introduction of nurse-midwifery care.

Since its beginning in eastern Kentucky, nurse-midwifery care has been introduced to other medically underserved areas characterized by poverty, geographical isolation and other social factors associated with poor obstetrical outcomes. Nurse-midwives screen carefully for indications of medical problems and collaborate closely with physicians when complications arise, thus identifying clients who are essentially medically normal from among the population characterized by social risk factors. Nurse-midwifery care has been shown to increase utilization of prenatal care, lower infant mortality and morbidity and to increase maternal well-being among these populations.

At the Frontier Nursing Service ". . . the maternal mortality rates averaged 9.1 per 10,000 births from 1925–1951; among white women nationwide the maternal mortality rate was 34 per 10,000. Since 1951, the FNS has not lost a single mother to birth related causes. FNS neonatal mortality rates in the years 1952–1954 were 17.3 per 1,000—less than the rest of Kentucky and the United States. Since 1971 the FNS perinatal mortality rates have averaged only 6 per 1,000 which is less than half the average of the rest of the country, even in its best year (14.5 in 1977), and better than the best country in the world, Sweden. The Metropolitan Life Insurance Company of New York estimated in a report in 1932 that if services like the FNS were adopted nationwide, the perinatal mortalities of the time would be reduced by 60,000 per year.[2]

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[1] C. Arden Miller, M.D., Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C, December 18, 1980.

Nurse-midwifery services in other rural areas, especially in the South and Southwest, have produced similar improvements in pregnancy outcome. The Medical Mission Sisters founded the Catholic Maternity Institute in 1943 to serve the impoverished mothers of Santa Fe County, New Mexico. The sisters offered prenatal care and birth at their Childbearing Center. Many births also took place in adobe homes with no electricity or running water. Prior to the program, in 1939, perinatal death rate of Santa Fe County were 87.6 per 1,000. By 1967 it had been reduced to 15.1, a level of achievement not to be attained by the country at large until over 10 years later. At that time, in 1967, the perinatal mortality rates of the United States were 22.1 per 1,000, while in New Mexico it was even higher at 24.8. . ."[3]

In the early 1960's a CNM practice was established as a pilot project in Madera County, California. Special legislation made nurse-midwifery legal for the duration of the project. Certified nurse-midwives were introduced as the only new variable in the medically understaffed county's health care system. The mothers served by the project were primarily agricultural workers.

During the first 18 months of the project, the Madera County prematurity rate dropped from its previous level of eleven percent to 6.6 percent and the neonatal mortality rate dropped from 23.9 deaths per 1,000 live births to 10.3 deaths per 1,000 live births. There was a significant increase in attendance at prenatal clinics during the pilot project. Mothers who had had no prenatal care and who were cared for during labor and delivery by nurse-midwives experienced a neonatal death rate of 26.8 per 1,000 live births. The neonatal death rate for mothers who had no prenatal care was 50.6 per 1,000 live births after the project ended the nurse-midwifery care during labor was no longer available.

Despite these goods results, the California Medical Society opposed legalization of nurse-midwifery and the nurse-midwives had to leave at the end of the project. After they left, the prematurity rate increased by almost 50 percent and the neonatal death rate tripled.[4]

In Holmes County, Mississippi, in 1971 the infant mortality rates had dropped from approximately 39 per 1,000 live births to 20 per 1,000 live births, two years after certified nurse-midwives began providing primary care to pregnant women as part of a community-wide focus on the health problems of mothers and babies.[5]

A study of the University of Mississippi Medical Center between October 1, 1972, and April 30, 1973, showed that nurse-midwifery clients kept by clients of the house staff physicians, It should be noted that clients of both physicians and nurse-midwifes did not see the same care providers at successive visits.

Among the nurse-midwifery clients 82.6 per cent had normal spontaneous vaginal deliveries; 62.1 percent of the house staff clients had normal spontaneous deliveries, with most of the difference found in the rate of low forcep deliveries by the house staff.[6]

At Su Clinica Familiar, a nurse-midwifery childbirth center in southern Texas, all maternity care for normal mothers is provided by certified nurse-midwives. The prematurity rate in 1974, two years after nurse-midwifery began, was 3.5 percent. In the same year in Texas the prematurity rate was 7.6 percent and for the nation it was 7.4 percent. The nurse-midwifery service has been operating since 1972. The clients are Mexican-American and Mexican women who are primarily migrant workers.[7]

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[2] D. Stewart, "The Five Standards for Safe Childbearing" (NAPSAC Productions, Marble Hill, Missouri, anticipated publication Spring 1981), p. 109.

[3] Ibid, p. 109.

[4] Barry S. Levy, Frederick S. Wilkinson and William M Marine, "Reducing Neonatal Mortality Rate with Nurse-Midwives," American Journal of Obstetrics and Gynecology, 109 (January 1, 1971): 51–58.

[5] Marie C. Meglen, "A Prototype of Health Services for Quality of Life in A Rural County," Bulletin of Nurse-Midwifery, XVII, No. 4 (November 1972): 103–113.

[6] C. Slone, H. Wetherbee, M. Daly, K. Christensen, M. Meglen, and H. Theide, "Effectiveness of Certified Nurse-Midwives," American Journal of Obstetrics and Gynecology, 124 (January 15, 1976): 177–182.

"In 1976 a nurse-midwifery program was begun in Mississippi County in northeast Arkansas. In 1975, 80 percent of births had occurred under general anesthesia in that county. In 1979 general anesthesia rates had fallen to 12 percent, while perinatal mortalities also dropped dramatically.[8]

"In 1941 the Tuskegee School of Nurse-Midwifery opened in Alabama offering services to the area. During the five years of its experience, neonatal mortality rates went from 46 per 1,000 live births to 14—more than a three-fold improvement." [9]

Nurse-midwifery services have also resulted in lowered infant mortality and morbidity rates among inner-city mothers.

In 1931, the Maternity Center Association (MCA) opened the Lobenstine Midwifery Clinic to care for immigrant families in upper Manhattan tenements. Between 1931 and 1951, 5,765 mothers registered with the clinic, of which 87 percent gave birth at home attended by (nurse-)midwives. Their maternal mortalities were less than one-third the national rates of the time. Their average neonatal death rates were only 15 per 1,000 while that of New York City as a whole ranged from 28.0 in 1931 to 18.4 in 1951." Kings County Hospital, New York City, opened a nurse-midwifery service in 1976. In the first 884 births, they had a neonatal mortality rate of 7.9 per 1,000, reflecting the deaths of 7 premature babies.[10]

At the North Central Bronx Hospital, whose clients come from one of New York's most distressed areas, where every patient receives nursing care of nurse-midwifery management from nurse-midwifes in labor, from January 1 to December 31, 1979, 88 percent of the mothers experienced normal spontaneous vaginal deliveries. Less than 30 percent of all mothers needed analgesia or anesthesia in labor. The neonatal death rate among infants 1,000 grams or over was 4.2 per 1.000.[11]

Since 1970, nurse-midwifery practice in the United States has expended to include two additional special populations, adolescents and economically affluent women. Adolescent childbearing carries social and medical risks which can often lead to poor obstetrical outcomes. Nurse-midwifery care, along with physician collaboration has been effective, and has been shown to improve the outcomes of teenage pregnancy.

Between 1976 and 1977 at a clinic for teenagers in Lincoln Hospital in New York City, nurse-midwifery care brought considerable improvement in outcome measures such as maternal weight gain and hematocrit. The rate of low birth-weight babies dropped from 18.1 percent to 6.3 percent.[12]

THE COST EFFECTIVENESS OF NURSE-MIDWIFERY CARE

The cost impact of nurse-midwives has only recently been a subject of research or discussion, as most research focused on the safety and quality of care of certified nurse-midwives. Both the available data and the characteristics of nurse-midwifery practice suggest that nurse-midwifery care is no more expensive, and often less expensive, than traditional obstetrical care.

A study conducted in rural Georgia showed significant improvement in infant outcomes and a decrease in health care expenditures after introduction of nurse-midwifery care.[13]

Nurse-midwifery care often opens the door to lowered costs through the use of non-hospital facilities, such as a birth center or the client's home, for normal births. The Blue Cross-Blue Shield of Greater New York audited the Childbearing Center started by the Maternity Center Association in New York City in 1976–1977. They found that care at the Childbearing Center cost 37.6 percent of in-hospital care, barring complications. The report also stated that the cost to Blue Cross-Blue Shield of Greater New York for families delivering at the Center was 66.1 percent of the cost to the plan had the family gone to the hospital, barring complications.

The cost to the health care system of full care at the Center has decreased each year, from a high in 1976 of $2,016.46 to $1,046.17 in 1979, as utilization increased.

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[7] Sr. Angela Murdaugh, "Experiences of a New Migrant Health Clinic," Women and Health, Vol. 1, No. 6 (November-December, 1976): 25–28.

[8] D. Stewart, op. cit., p. 112.

[9] Ibid., p. 111.

[10] Ibid., p. 115.

[11] Doris Haire, "Improving the Outcome of Pregnancy Through the Increased Utilization of Midwifes," Journal of Nurse-Midwifery, Vol. 26, No. 1 (January-Feburary, 1981): 5–8.

[12] M. Brenda Doyle and Mary V. Widhalm, "Midwifing the Adolescents at Lincoln Hospital's Teen-Age Clients." Journal of Nurse-Midwifery, Vo. 24 No. 4 (July-August 1979): 27–32.

[13] Michael L. Reid and Jeffrey B. Morris, "Perinatal Care and Cost Effectiveness: Changes in Health Expenditures and Birth Outcome Following the Establishment of Nurse-Midwife Program," Medical Care, 5, Vol. XVII, (May 1979): 491–500.

The Childbearing Center staff expect the Center to be self-supporting with 600 families in the program annually. In late 1980 the Center had over 500 families enrolled and expected to meet their goal very shortly.

Medicaid is currently paying from $1,649.53 to $2,230.04 for normal care with a three-day hospital stay in various New York hospitals. The Childbearing Center currently charges $1,000 for its whole package of prenatal, intrapartum and postpartum care: the Center receives $885 for total care from Medicaid and the Center is appealing that rate.

The care at the Center is economical because clients have the opportunity for prolonged contact with professionals, including the nurse-midwives who are with them in labor and delivery. A client's stay at the Center is much shorter than the typical three-day stay and she receives intensive, personalized care during that time.

The Center is also economical because non-hospital facilities, the Center and the client's home are used as settings for provision of care. The Center's all inclusive fee of $1,000 compares favorably with the $3,000 for hospital and obstetric fees which private care in New York City can cost.[14]

Another mechanism often associated with cost savings and midwifery care is the shortened hospital stay for a healthy mother and baby. Midwifery care during pregnancy and availability by phone or home visit during the early postpartum period set the stage for the well-prepared family to go home within 12 to 24 hours after a normal labor and birth.

In Washington, D.C. the current cost of prenatal, delivery and postpartum care with a nurse-midwifery service is $800 for each client planning to deliver in the hospital. This includes prenatal care, labor management and delivery, postpartum care, a two week, six week, six months and one year checkup and three postpartum classes. Physician's fees vary from $800 to $1,200 and include prenatal care, labor and delivery management, postpartum care, and a six weeks check-up. Hospital costs for nurse-midwifery clients who spend 6 hours or less in the hospital after delivering are around $600 for each woman. Clients who stay the traditional three days will pay close to $1,000 in hospital costs.[15]

Most nurse-midwives are employees who have no control over prices charged to clients. As more nurse-midwives go into practice with physicians and establish private nurse-midwifery practices, we will begin to be able to assess the financial impact of private nurse-midwifery practice. CHAMPUS began reimbursing nurse-midwives within the past year and is conducting a study of the impact of nurse-midwifery reimbursement on their maternity care costs.

While the data are limited, several characteristics of nurse-midwifery practice suggest that nurse-midwives deliver cost-effective care. The average salary of a nurse-midwife in clinical practice in 1976 was $16,200. Contrast this figure, which has certainly improved somewhat since 1976, with the median income of any obstetrician-gynecologist, which was $89,310 in 1979. Nurse-midwives' services have to cost employing institutions less than obstetricians'.

As we have seen earlier, nurse-midwives have a proven record in reducing infant morbidity and mortality. The reduction in prematurity and low birth weight rates in the many places nurse-midwives have worked certainly must also have meant a reduction in dollars spent by states and private companies on intensive care nurseries. An official of the University of Mississippi, Peter H. Meyers, has compared the taxpayers' cost for nurse-midwifery education with the savings reaped through improved pregnancy outcomes.

Looking at 76 graduates over a three-year period, I found their median age to be 31. Assuming that on the average 74 percent of them work until age 65, delivering 15 babies per month and referring 5 others, I can anticipate that they will provide primary care for 583,680 mothers, delivering 437,760 babies.

Using a very conservative cost for lifetime institutionalization of $500,000 we can say that if only 4 out of 583,680 babies have radically different outcome (family support rather than lifetime institutionalization) the taxpayer breaks even. The break-even point is reached if fewer than 1/1000 of 1 percent (.0000068) of "our" babies avoid lifetime institutionalization. I would, more realistically I believe, predict a savings to taxpayers of many hundreds of times the program's cost.

Cost effectiveness includes other costs such as the cost of delivering care, and the cost of nursing school; but these costs are often borne in large measure or entirely by private parties.

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[14] Ruth W. Lubic, CNM, Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., December 18, 1980.

[15] Maternity Center Associates, Bethesda, Maryland, personal communication.

None of this deals with maternal or infant mortality or maternal morbidity. What are the social costs when a mother dies? How often do her children become temporary or permanent wards of the state? What does that cost the taxpayer? I can't even guess.[16]

Nurse-midwives are educated to use technology only when it is indicated by a client's condition. Such limited, rather than routine, use of machines and laboratory tests should result in savings for individual customers. Nurse-midwifery clients often use less analgesia or anesthesia in labor.

A Caesarean birth can add as much as $1,000 to a physician's fee and as much as $3,000 to hospital fees. Nurse-midwifery services have Caesarean birth rates which are significantly lower than the U.S. rate which is approaching 30 percent in many facilities. The Caesarean birth rate at the nurse-midwifery service at the North Central Bronx was approximately 13 percent in 1979, for example.[17]

A nurse-midwifery service would be less expensive for the federal government to establish than a physician's practice because nurse-midwives need less complicated equipment. They need only to have access to high technology through their collaborating physician.

In additional to potential cost savings, nurse-midwives bring to each birth a concern for the psychological and cultural factors which affect the birth experience of the mother, family and infant. Ample research has shown that the nature of the birth and immediate post-birth experiences have a strong impact on later infant-parent relationships. The evidence suggests that positive birth experiences correlate with lower incidences of child neglect and abuse. Nurse-midwives strive to help parents create positive birth experiences and this must make an indirect contribution to lowered financial and emotional costs to society as a whole.

The information available and the logical conclusions drawn from examination of nurse-midwifery practice prove that nurse-midwifery care is a cost-effective means to providing safe, satisfying maternal and child health care.

OBSTACLES TO WIDER UTILIZATION OF CERTIFIED NURSE-MIDWIVES

Among the six obstacles to greater federal utilization of certified nurse-midwives which the GAO report identifies, the limited supply, few training programs, reluctance of some nurse-midwives to practice in less desirable areas, restrictive state licensing or third party reimbursement, non-availability of obstetricians with whom to work, physician resistance is the most difficult problem.[18] This problem was recently the subject of an investigatory hearing held by the Subcommittee on Oversight and Investigation of the House of Representatives' Energy and Commerce Committee.

The resistance occurs despite the demand for nurse-midwives by consumers, state governments and federal agencies, despite the record of improved health for mothers and babies, despite cost effectiveness and despite the widespread employment of nurse-midwives throughout the country. Resistance to nurse-midwifery practice is strong and seems to be gathering strength.

While this resistance is described in some detail, it is important to remember the co-existing reality that in many communities nurse-midwives, physicians and hospitals have formed mutually satisfying professional relationships. The ACNM and the American College of Obstetricians and Gynecologists (ACOG) often work together on issues of importance to mothers and babies. Nurse-midwifery practice was officially endorsed by the American College of Obstetricians and Gynecologists (ACOG) and the Nurses Association of the American College of Obstetricians and Gynecologists in a statement issued jointly with the ACNM in 1971 and in a supplemental statement in 1975. The ACNM has benefited from and appreciated ACOG's official support.

The incidence of resistance is widespread and has been found in recent months in Massachusetts, New York, New Jersey, Pennsylvania, Washington, D.C., Maryland, Delaware, South Carolina, Tennessee, Illinois, and South Dakota. Resistance comes from many sources: individual physicians, professional organizations such as medical societies, hospital department of obstetrics, public bodies such as state boards of health and state medical practice boards, insurance companies, and occasionally nursing.

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[16] Peter H. Meyers, University of Mississippi, Nurse-Midwifery Education Program, personal communication, Spring, 1981.

[17] Doris Haire, "Improving the Outcome of Pregnancy Through the Increased Utilization of Midwives," Journal of Nurse-Midwifery, Vol. 26, No. 1 (January–February, 1981): 5–8.

[18] General Accounting Office, "Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome," (General Accounting Office, Washington, D.C., 1979).

The form which the resistance takes varies as well. It includes refusal to provide medical collaboration, refusal of permission or privileges for use of hospital facilities, placement of unjustifiable restrictions on nurse-midwifery practice or settings, refusal of third party payors to reimburse nurse-midwives, harassment of physicians who support nurse-midwifery practice, request for unreasonable payments for liability insurance and misrepresentation of the nature of nurse-midwifery practice to the public.

In Washington, D.C. Georgetown University Medical Center has consistently refused to allow nurse-midwives to practice in labor and delivery, even though the school of nursing has had a nurse-midwifery education program for several years.

In New Jersey the Board of Medical Examiners has issued regulations which restrict nurse-midwifery practice and which prohibit nurse-midwives from caring for women under 16 and over 35 years of age. These regulations have a severe impact on nurse-midwives and their clients, especially adolescents, in New Jersey.

In Nashville, Tennessee the two nurse-midwife members of an obstetrician-nurse-midwife team were denied privileges at three hospitals in which their physician practiced. Their physician experienced such strong harassment from his colleagues, including cancellation of his insurance by the physician-owned malpractice insurance company, that he has left Tennessee. No other physician in Nashville is willing to collaborate with nurse-midwives in private practice. The nurse-midwives have been forced to close their business and undertake expensive legal action. They will be filing suit in a few weeks.[19]

When Maternity Center Association in New York City opened its Childbearing Center, an out of hospital birth center, they did so despite the opposition of a wide array of state agencies, state physicians' organizations and national physicians' organizations.[20]

In Englewood, New Jersey, the Childbirth Center has struggled to survive in the face of opposition from local physicians, the Board of Medical Examiners and a major insurance company.[21]

In Washington, D.C., a private group practice of three nurse-midwives who do home births embarked a year ago on a pilot experiment doing hospital births at the Washington Hospital Center. In order to obtain privileges the nurse-midwives became technically the employees of their collaborating physicians who already had privileges. Although the first year went well, the hospital's Department of Obstetrics and Gynecology voted to end the nurse-midwives' privileges because they are also doing home births. The decision has not been carried through by the hospital's board of directors because of the large public outcry against the decision. The Department of Obstetrics has formed a committee to review the nurse-midwives' charts. There are no nurse-midwives or pediatricians on the committee.[22]

While scores of rationales for these obstacles exist, and each incident is flavored with its own particular legal, administrative and interpersonal characteristics, two themes emerge from the arguments against nurse-midwifery practice. The first of these is the issue of quality of care and of patient safety. The rare, and often preventable occurrence of a complication of pregnancy or birth is often cited as the reason for preventing nurse-midwives from practicing or for limiting the scope of their practice to less than that for which they have been educated. Two assumptions underlie that rationale. The first is the idea that while nurse-midwives are better than no prenatal or intrapartum care at all, the physician is always more desirable because of his or her education in dealing with complications. The statistics refute that claim. The record of nurse-midwifery care in the United States in reducing infant mortality and morbidity shows that nurse-midwives are safe. Countries with lower infant mortality rates than the United States' rely heavily on professional midwives.

The second underlying assumption is that the speed with which severe complications arise is great enough to justify physician presence throughout labor and delivery managed by nurse-midwives. It is important to remember that pregnancy and childbirth are normal physiological practices. Normal, healthy pregnancy and delivery are the predominant realities of childbearing. Complications are the exceptions, not the rule. Nurse-midwives, unlike most physicians, are able to be in constant attention throughout labor. Thus, nurse-midwives detect problems at the earliest moment and often avert them. Extremely serious complications which develop rapidly are extremely rare. Many common complications of labor and delivery result from the routine interventions of traditional medical care which do not characterize routine nurse-midwifery care. Nurse-midwives are educated to recognize the symptoms of complications, to begin the appropriate interventions and to call for assistance immediately when complications arise.

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[19] Susan J. Sizemore, C.N.M., Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., December 18, 1980.

[20] Ruth W. Lubic, C.N.M., Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Committee, U.S. House of Representatives, December 18, 1980.

[21] Lonnie H. Morris, C.N.M., Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., December 18, 1980.

[22] Marion McCartney, C.N.M., Testimony to the Subcommittee on Oversight and Investigation, Interstate and Foreign Commerce Committee, U.S. House of Representatives, Washington, D.C., December 18, 1980.

The second theme which emerges in the resistance of nurse-midwifery practices is that of "independent practice." Licensure, direct third party reimbursement, home birth services and out-of-hospital birth centers all raise the question of whether nurse-midwives are, or should be, "independent practitioners". "Independent practice" appears to mean a nurse-midwife hanging up her shingle in a solo practice patterned after the independent business of the solo physician in private practice. The implication of this model is that the nurse-midwife would be practicing without back-up physician, without the system for consultation with physicians, referral of clients to physicians and without the collaborative management of client care by both a nurse-midwife and a physician which are an integral part of the definition of nurse-midwifery practice. The record needs to be very clear on this matter. Nurse-midwives do not practice midwifery in the "independent practice" model of the private solo practice which characterizes much physician practice. The "Functions, Standards and Qualifications for Nurse-Midwifery Practice" states that nurse-midwifery practice "Occurs interpendently within a health care delivery system. Occurs within a formal written alliance with an obstetrician; or another physician, or a group of physicians, who has/have a formal consultative arrangement with an obstetrician-gynecologist; exists within a framework of medically approved protocols." [23]

The dictates of the "Functions, Standards and Qualifications for Nurse-Midwifery Practice" are clearly explained by Helen Varney, the current president of the American College of Nurse-Midwives in her recently released textbook of nurse-midwifery. "'Independent management' refers to the fact that a patient may never seen a physician if her course essentially is normal and she is managed by a nurse-midwife. Thus, the practice of nurse-midwifery within the protocols for practice, which define the practice and provide for medical consultation and referral is independent . . . Independent practice means without medical protocols for formalized physician back-up. A certified nurse-midwife always functions within a health care system in a team relationship with a physician and is never independent of physician back-up for consultation, collaborative management, or referral." [24] Should a nurse-midwife be thought to be violating the principles established in "Functions, Standards, and Qualifications," she would be subject to investigation by the American College of Nurse-Midwives and would be vulnerable to censure, suspension, expulsion or decertification.

Nurse-midwives have always practiced and will continue to practice in collaboration with physicians; that relationship will not change. What has begun to change, however, is the employment relationship between the nurse-midwife and her collaborating physician. Nurse-midwives are now not always employees of physicians or hospitals. In some cases the nurse-midwife has joined the practice of her physician partners. In other cases, nurse-midwives are employing physicians to provide them with consultation and referral services. Nurse-midwives are increasingly eligible for direct third-party reimbursement. Many private insurance companies including Connecticut General, Travelers, Aetna, and all union insurance programs, will reimburse nurse-midwives in all states. New Mexico, Utah, and Maryland have adjusted their insurance codes to include direct reimbursement to nurse-midwives. All of these changes mean there is substantially more competition in the obstetrical market place. All of these changes mean that a nurse-midwife may become economically independent of her physicians or hospital back-up services. Her prefessional interdependence with physicians and hsopitals remains and always will.

Chairman **Jacobs**. Thank you, Ms. Tom.

I might say in my experience since 1964, when I first came to the Congress, I believe, if I am not mistaken, you are the first witness who ever prefaced her testimony with the salutation "Hi." I find it very refreshing.

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[23] American College of Nurse-Midwives, "Functions, Standards and Qualifications for Nurse-Midwifery Practice," Washington, D.C., 1975.

[24] Helen Varney, C.N.M., "Nurse-Midwifery" (Blackwell Scientific Publications, London, 1980).

Mr. Gradison.

Mr. **Gradison**. No questions.

Mr. **Duncan**. No questions.

Chairman **Jacobs**. Mr. Gephardt.

Mr. **Gephardt**. Hi, Mr. Chairman. I appreciate this opportunity.

Chairman **Jacobs**. You don't qualify, you are not a witness.

Mr. **Gephardt**. I appreciate your testimony. I guess what you are all basically saying is that you really think that we should continue regulating the system the way we have and in fact you would want more regulation in the use of national health insurance, in the traditional style in order to improve access to the system and to improve cost efficiency; is that a fair statement?

Ms. **Fagin**. I am not really sure it is. But you may know more about it than I do. I assume you do, actually.

Mr. **Gephardt**. I am sure I do.

Ms. **Fagin**. Let's start with that assumption. It seems to me that in order to institute anything that has to do with competition you have to open the system. You are not going to have a competitive health care system unless you have competitive providers. To have competitive providers sometimes you have to take the power out of the hands of the people who are the dominant providers who really are not competitive with each other.

Do we agree on that?

Mr. **Gephardt**. But if we regulate so that we make sure everybody is written into the system, that everybody's services have to be included in any qualified plan, then we have gotten rid of competition and we have gotten rid of the consumer making choices and we have made those choices for them by using our powers, the last speaker said, to make sure that people get to choose that particular kind of service.

That is really the antithesis of competition, it is the promotion of the ultimate regulation. And in my view, it dictates that the Government should run the system and cause the cost to go up.

Ms. **Fagin**. How does that differ then from my being able to go to an extremely expensive department store to buy a dress rather than being forced to go to Bergdorf-Goodman? Do we enter that marketplace and control the department stores that are able to offer sizes, thus injecting regulation into the system so that I have the right to buy a cheaper dress than Tom Nickels' wife has a right to buy?

I don't follow your logic there. What we are saying is the consumer has a right to documented high-quality, lower cost services.

If you are to issue the goals you are seeking in your bill you are going to have to introduce providers who have those kinds of services to offer. The research has shown, the midwives are the best case in point, because we now have about 20 years of solid research about the cost benefit results of midwife practice.

They are not only cheaper, sometimes by 50 or more percent, but they are also extremely high quality.

Mr. **Gephardt**. But we do nothing in our bill to write them out or say that they cannot be included in plans. Our view is that if their service is as good and as cost effective and as necessary and as efficient as they think it is, then it should be included in plans and would be included in plans.

But if we get into the business here in this committee as we have been in medicare for many years of deciding the optometrists ought to be in or the chiropodists ought to be or the psychiatrists ought to be in, then we are deciding what health care is for the American people and we are deciding which kind of practice is the one we want offered.

I don't want to make these decisions. I want the American people to make those decisions. And I want to make sure that we have constructed a situation where everyone has the freedom to compete and to be accepted by the American public or not or parts of the American public or not. And it has to be one way or the other, I think. Either we have to construct a system where the consumer is able to make those decisions or we decide they are not capable of it and we will dictate those decisions from this room and the Senate Finance Committee.

In your statement you said while agreeing consumers are shielded from the true consequences of their decisions, you question the logic and fairness of placing an unfair burden on them of making these decisions. It either has to be done one way or the other, I think.

Ms. **Fagin**. I agree with you. But my belief is that the consumer neither has the information nor the access to make appropriate decisions. So the consumer in a particular State—we will stick with the midwives since we have one here who could give additional data—the consumer in a particular State who has acquired the information, has the intelligence, is able to make the choice, wants to use a midwife in some States can, in some States cannot, because they cannot be reimbursed.

There is restraint on the practice of midwives, there is restraint on the practice of pediatric nurse-practitioners and general medical practitioners within States. These are restraints that you cannot affect directly but they are restraints that have to be removed in order to meet the goals you have described.

Mr. **Gephardt**. I say to you if you go to a voucher system, for instance, in medicaid, take that as an example, I think the services of groups like this would have to be offered under this kind of legislation to everyone.

We do preempt State laws that affect costs, we do not preempt State laws that affect quality. There is going to be as you well know, a fight over which is which. But my view is that the very thing that you are trying to get offered to people is what I want offered to people, but I don't want the Congress dictating that that is a service that is to be included in each and every plan.

Mr. **Tendler**. I think you are operating on the assumption that everybody is making an educated decision; and second, that all providers are equal. I think those two assumptions are wrong. And if we proceed on that assumption you can't have a fair system without regulations.

As far as licensed practical nurses are concerned, we are not wedded to the present system or the traditional approach. Certainly regulations have been a hindrance in many circumstances to both, us as providers and to the consumer in receiving health care.

But I think the system as you present it is an unrealistic system, with all due respect, because there are not educated decisionmakers out there.

Second, not all providers are equal. I think the classic example is the nurse practitioner. She or he is prohibited in many States from practicing and being reimbursed and yet studies have indicated that nurse practitioners on many levels have been able to reduce the cost of health care and not really reduce the quality of health care.

Mr. GEPHARDT. Well, I understand what you are saying. As I said, we have tried, I think, in the bill to make sure those restraints, unreasonable restraints, are not there. But I think we just basically disagree on what Government should do and what regulation should try to accomplish.

You think that we should make those decisions for people. I disgree. You think we should make everybody equal. I guess I disagree with that. I think if you got a service that is marketable, that is usable, that is efficient, that the best we can do is create a marketplace where you can market that service and that if it is really good, it will find its place in the marketplace and if it is not, it won't.

I don't think the Government should be in the business of deciding, with regard to each and every service, who is good, who is bad, who should get in and who shouldn't.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Gephardt, thank you. Ms. Fagin, you were talking about educated choices by consumers of health care. I suppose the freedom to choose could be carried to its logical conclusion so that each of us, when he or she becomes ill, might choose among prescription drugs, rather than having some authority determine which prescription we are allowed to walk into the drugstore and buy. So I perceive an extreme in either direction. Would you agree with that, do you see some analogy there?

Ms. FAGIN. I am sure, you know, in some countries you can do exactly what you just said, you can go into a drugstore and ask for a prescription drug and buy it.

Chairman JACOBS. Thalidomide, for example, should the carrier have that?

Ms. FAGIN. No.

Chairman JACOBS. That was a situation, as I recall, in Europe; I suppose it was licensed in some places but apparently—who was the doctor in the Food and Drug Administration—Dr. Kelsey, was it?—she was almost fired from her job for objecting to the marketing of Thalidomide. Now there is Government regulation, my father used to say, "Some people prefer regulation to rigor mortis." I think Mr. Gephardt, without question, in my mind, is one of the most thoughtful and innovative Members of the Congress. He has been responsible for a great deal of progressive legislation, and I think that the mere fact that he has introduced this bill and brought out the discussion has been a tremendous service. It raises other questions that ought to be explored. Here is one of them.

I suppose that we are not very much in a demand market right now in the health care industry, are we? I mean so far as medical care is concerned. It goes up in price every year, beyond the Consumer Price Index.

Ms. FAGIN. Just like the apparent plethora of health care practitioners in the market.

Chairman JACOBS. Yes. My question is: If you reduce demand, do you think you would improve the balance in the health care system?

Ms. FAGIN. I would have to respond for myself, naturally, instead of my organization. I believe you would. I think part of the information problem has to do with where people believe the authority lies. And we have really given over too much and, again, it is a fine line you are asking about. We have given over too much of the authority for our own decisions and our own bodies and our own knowledge to other people and have come to believe that we know very little about ourselves, very little about our bodies, about how to maintain health and things of that sort.

Clearly, with a different focus on where—my own belief, for example, is that deductibles and copayments ought to occur at a different point in the system, that we should not be discouraging information seeking in preventive care; we should be operating at a different level in terms of when people seek health. Many of us are able to care for a very large part of our own health maintenance activities, if we know how to do it.

Chairman JACOBS. That is what I have been edging on toward. I promise not to do this again during the hearings. But you are the unlucky one. I want to ask this question: After all is said that can be said and all the complications of Federal regulation and medically sensing and all the rest, how much of it comes down to the kind of prevention that is embodied, if that is the word, in abstinence from tobacco, abstinence from certain kinds of food—I will whisper the word sugar—around here that is pretty dangerous—and so forth. Diet, for example, the ounce of prevention, isn't that something that ought to be said to this country—that an ounce of prevention is worth billions in care?

Ms. FAGIN. It has been said. I think the research of the epidemiologists would say that the preventive measures that have large societal implications have had the most effect on our mortality rates and so forth, but what people really believe in, in our country and I don't think we can blame anyone for it—it is sort of a conspiracy between us and the providers—is that high technology is what really counts.

It is very hard to change people's beliefs in a system like ours. Rhetoric alone, obviously, will not do it. But smoking, out of the list you gave, clearly is one of the areas of prevention that has been shown to have the most major effect in terms of preventive services. But where that has occurred, it is usually with people who already have something wrong with them.

In other words, if you can effect a population who has already had a myocardial infarction, by changing their smoking habits—which indeed has been studied with nursing intervention—you will markedly alter the course of their further life and the possibility of their future occurrences of myocardial infarction. But we know that the smoking habits of the adult population have changed markedly in our country, the adult population.

Chairman **Jacobs**. I don't think it is generally known, but when the Nazis occupied Norway in World War II they effectively deprived the population of a meat diet, instead using it themselves. And according to statistics, as I read the literature, they did a big favor for the Norwegian people. The health statistics in terms of good health soared during that period of time.

I don't know if there is any lesson there for anybody or not. But if there are no further questions, I will say goodbye. Thank you all.

The committee is pleased to welcome our colleague, Congressman Grisham, who will present to the committee his constituent.

Why don't you just proceed.

STATEMENT OF INTRODUCTION BY HON. WAYNE GRISHAM, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. **Grisham**. Mr. Chairman, thank you, sir. I would like to thank the committee for holding these hearings on the Basic Health Insurance Tax Credit Act. The Subcommittee on Health has always excelled in its desire to consider the major health questions facing the country.

The Basic Health Insurance Tax Credit Act will serve to amend the Internal Revenue Code to provide individuals a refundable income tax credit for premiums paid for basic health insurance. I am fortunate to have someone living in my district who has tremendous expertise on this type of health care legislation.

Mr. Chairman, I am proud to be able to introduce Dr. J. Elder Bryan. Dr. Bryan, a urologist by training from Downey, Calif., has been a prime force in the movement to establish cost-conscious measures in medical care. His unselfish dedication to his profession and his continued contributions to the Los Angeles area medical community has earned Dr. Bryan the respect and honor of his colleagues throughout the Nation.

Dr. Bryan's concept is supported by patients, by doctors, and by hospitals. He is supported by patients because they have the freedom of choice to select their own hospital and own doctor, and second, because they get their money back, they are supported by the hospitals and doctors because it gives them the right to compete and the right to serve the patient.

Dr. Bryan will present the goal, concept, and proposed solutions for improved financing and control of the escalating cost of medical care. His testimony and this bill deserve strong consideration.

Mr. Chairman and members of the committee, I now have the honor of presenting Dr. J. Elder Bryan.

Chairman **Jacobs**. Welcome to the committee. Please proceed.

STATEMENT OF J. ELDER BRYAN, JR., M.D., LOS ANGELES, CALIF.

Dr. **Bryan**. Thank you, Mr. Chairman and members of the committee. Thank you, Mr. Grisham.

H.R. 3472 is a bill to amend the Internal Revenue Code of 1954 to provide individuals a refundable income tax credit for premiums paid for basic health insurance and a deductible from gross income for certain additional medical expenses.

BASIC HEALTH INSURANCE TAX CREDIT ACT

(b) PURPOSE.—The purpose of this Act is to establish a system of protection against medical and health care costs which is easy to use and simple to administer by providing for a refundable tax credit for basic health insurance premiums paid by individuals, and to facilitate the participation of the private health insurance industry in the provision of medical and health care for the needy and indigent.

How does it work? In order for a family or individual to qualify for the tax credit, they must have a health insurance policy which includes these provisions.

Incidentally, the outline for this was given to me several years ago when Del Clawson introduced me to Representative Dan Rostenkowski, who suggested that the parameters for a basic health insurance for which a tax credit could be considered would be one with no first dollar coverage, with a large deductible to encourage prudent purchase of health care and copayment to a reasonable level so that the people would not become financial cripples, and then 100 percent coverage when they really needed the care for cardiac or renal transplant or whatever.

Mr. Grisham has put into this bill no first dollar coverage for at least the first $1,000 of medical care expense.

Coverage for not more than 80 percent of medical care costs between $1,000 and $15,000.

Total coverage of all expenses over $15,000.

That would mean a total out of pocket in any 1 year of $3,800 for anyone who had the maximum expenses. This compares favorably with the $3,500 per year in S. 433. Those people who would benefit from this would be primarily the people mentioned just a few moments ago who have no insurance now and then those who already have their own insurance. The ones who have no insurance would be encouraged to buy insurance because they would get a tax credit for buying the basic health insurance policy. Senior citizens would benefit because premiums under part B of title XVIII of the Social Security Act shall be treated as premiums for basic health insurance.[1]

Others who would benefit would be those already under group plans, and they could ask their employer to switch them to receiving the cash being spent for premiums. This would be taxable. They, in turn, would buy their own policy or through their company, would have it deducted from their wages and get a tax credit which would have to be put on their W-2 form.

How would it help the needy? Del Clawson about a year ago gave a chart to me. I checked with him this past week and he said it is just as accurate now as it was then; that for people to donate to the needy is much less expensive than to have it come to Washington and be "laundered" and go back with a 75-percent shrinkage.

How practical is it? Even without this bill, in our own office we have switched to a $2,000 deductible policy. This first year we are saving $6,000 in premiums which will go into the pension fund for the girls in the office and for myself. We have still guaranteed them that they would have $100 deductible, we would self-insure for that up to that first $1,000.

What are some of the cost comparisons? Mr. Durenberger's bill recommends certain amounts be allowed to be deductions by the employers. That would average out to $1,100 per year per employee, and in our bill, if you use the one closest to the basic health insurance bill, it would come out at about $606 per year as a tax credit, which is allowing the patient to use his own money for what is best for him. It is a much better way of going. The average cost of insurance, in a more expensive policy of Blue Shield of California, that is, with only $100 deductible, averages out $1,042 per year, which is still less than the Durenberger proposal.

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[1] H.R. 3472, p. 4, lines 14-19.

Other benefits when H.R. 3472 is compared with the procompetition bills are as follows: (1) has low initial cost, therefore small tax credit, (2) large deductible concept encourages prudent use of health insurance and (3) 100-percent coverage when really needed. In my own office it is much easier to ask a patient to go in for major surgery when he knows he needs it than it is to ask him to have an X-ray in the office on the first floor of our building, where he would have to pay for it himself. Patients say, "Admit me to the hospital for this X-ray"—that would be at least $300 a day—"my insurance pays for."

Who pays for it? "My company pays for it." Patients have a poor concept of the cost of medical care. A large deductible is the only sensible way, as Mr. Rostenkowski suggested several years ago, and also about 6 years ago Dr. Joseph Newhouse of the Rand Corp. put out a paper on the cost of medical care and how we could control it. He said the only possible way of controlling the cost of medical care is asking the patient to be responsible. The same as if you had free choice to pick out a car; you could pick out a Rolls Royce, but if you have to pay for it, as my son would have had to last week when we went to look at an economical Ford, it is a different story. Even that was too expensive as he didn't purchase it and is driving his repaired car.

Chairman Jacobs. Rolls Royce is a gas guzzler.

Dr. Bryan. How can 3,472 help local savings institutions? If the people had $1,000 deductible to meet, they would be putting money into the savings account in case this emergency came along. They would be learning to save, something that the people voted for last fall to get money back into their own communities. Having a savings account against which one could borrow in case of need. We have worked that out with our local bankers and have some good figures on it. This is shown in your chart in the formal presentation.

What it is not, it is not a change of current group or government insurance plan. It does not do away with medicaid, medicare which can be worked into it, since it doesn't regulate them out. It is not an excuse for new regulations or the establishment of a new bureaucracy to dictate the financing of health care insurance. It is not a punitive system for the control of employers. It is not compulsory.

Chairman Jacobs. Thank you for your testimony. Mr. Gephardt.

Mr. Gephardt. I have no questions. I appreciate very much your testimony and share many of your views. I think the idea of getting consumers to bear some responsibility in the whole equation is essential if we are to bring down cost. I think it is a much more effective way than having the government try to regulate the providers to get it done. I appreciate your sentiments.

Chairman **Jacobs**. Mr. Gradison.

Mr. **Gradison**. Thank you very much. I just want to thank you, Doctor, for taking the time to come all the way down here and share these very useful thoughts with us. It is extremely helpful.

Chairman **Jacobs**. Doctor, I echo that. There is a vote on. The Chair declares a recess for about 6 or 7 minutes.

[Recess.]

[The prepared statement follows:]

STATEMENT OF J. ELDER BRYAN, JR., M.D., LOS ANGELES, CALIF.

H. R. 3472

1. WHAT IS HR-3472?

It is a Bill to amend the Internal Revenue Code of 1954 to provide individuals a refundable income tax credit for premiums paid for basic health insurance and a deductible from gross income for certain additional medical expenses. *(HR 3472, p.1, ln 5-7, p.2, ln 2-5)*

"Basic Health Insurance Tax Credit Act".

(b) PURPOSE.—The purpose of this Act is to establish a system of protection against medical and health care costs which is easy to use and simple to administer by providing for a refundable tax credit for basic health insurance premiums paid by individuals, and to facilitate the participation of the private health insurance industry in the provision of medical and health care for the needy and indigent.

2. HOW DOES IT WORK?

In order for a family or individual to qualify for the tax credit, they must have a health insurance policy which includes these provisions:

- No coverage for at least the first $1,000 of medical care expense.
- Coverage for not more than 80 percent of medical care costs between $1,000 and $15,000.
- Total coverage of all expenses over $15,000.

The tax credit would be based on going rates for the cost of insurance in a person's given situation. The amount would vary with individual age and sex, with family size and with the geographical location in the country. *(HR 3472, p.2, ln 12-25, p.3, ln 1-13, p.6, ln-21-24, p.7, ln 1-7) (Chart 2a, 2b, 3, and 4a)*

"SEC. 44F. PREMIUMS FOR BASIC HEALTH INSURANCE.

"(a) IN GENERAL.—In the case of an individual, there shall be allowed as a credit against the tax imposed by this chapter for the taxable year the amount paid by the taxpayer during such year as premiums for basic health insurance.

"(b) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) BASIC HEALTH INSURANCE.—The term 'basic health insurance' means, respect to any taxpayer, insurance—

"(A) which is purchased by such taxpayer to cover medical care expenses incurred by himself, his spouse, or his dependents (as defined in section 152), and

"(B) which, for each year with respect to the medical care expenses of each individual covered by the insurance, provides—

"(i) no coverage for at least the first $1,000 of medical care expenses,

"(ii) coverage for not more than 80 percent of medical care expenses in excess of—

"(I) the amount of medical care expenses for which no coverage is provided, but

"(II) not in excess of $15,000, and

"(iii) coverage for all medical care expenses in excess of $15,000.

"(a) ALLOWANCE OF DEDUCTION.—There shall be allowed as a deduction the amount of any expenses paid during the taxable year, and not compensated for by insurance or otherwise—

"(1) for medical care of the taxpayer, his spouse, and his dependents (as defined in section 152), and

"(2) for medical care of any other individual who (as determined under regulations prescribed by the Secretary) is needy or indigent,

to the extent that such expenses paid by the taxpayer during such year exceed $500."

FOR TAX PURPOSES

1. TAX CREDIT FOR INSURANCE.
2. OTHER MEDICAL EXPENSES:
   - A. $500 EXCLUSION/DEDUCTIBLE.
   - B. THEN STRAIGHT DEDUCTION FROM GROSS INCOME ON ALL ALLOWABLE EXPENSES FOR TAX PURPOSES.

3a

PARAMETERS OF INSURANCE COVERAGE QUALIFYING FOR TAX CREDIT

A. $1000 deductible.

B. 80/20 coverage of the next $14000.

C. 100% coverage above $15000 expenses.

MAXIMUM OF $3800 OUT OF POCKET PER YEAR -$3300 DEDUCTIBLE FROM GROSS INCOME FOR TAX PURPOSES.

3b

(3)

OTHER TAX PROVISIONS:

- o $500 tax exclusion of medical expenses, then all additional medical expenses are deductible from gross income.
- o additional cost of other insurance for more comprehensive coverage than the "BASIC HEALTH INSURANCE" may be applied to the $500 exclusion.
- o gifts designated to medical care or insurance for the needy, given to any qualified charitable organization, are treated as charitable donations.

3

$1000 calendar year deductible

80% of first $10,000 and 100% thereafter per year

lifetime maximum of $1,000,000

Blue Shield of California Coronet —Plan 938 —

AGE OF SUBSCRIBER	UNDER 30 YEARS	30 TO 44 YEARS	45 TO 54 YEARS	55 TO 64 YEARS
MALE	$185.40	$266.40	$450.80	$628.80
FEMALE	$215.40	$306.80	$523.80	$732.00
FAMILY OF TWO	$366.00	$535.86	$826.80	$1149.60
FAMILY OF THREE OR MORE	$505.70	$696.00	$988.20	$1322.40

Note: Average Cost of Insurance, Including All Categories:

S-433 is $1100 per year — allowable for tax deduction.
HR-3472 ($1000 Deductible) is $606 per year — tax credit.
HR-3472 ($100 Deductible) is $1042 per year — tax credit and exclusion.

48

3. WHO WILL BENEFIT FROM HR-3472 ?

Benefits will occur primarily to the 12 percent of the people in this country who do not have health insurance plus those who have private health insurance policies.

Others who could benefit would be those under group insurance policies who ask their employer for their insurance benefit in cash so they can purchase their own insurance.

Examples:

- Receive cash - pay tax. Purchase insurance privately and get the tax credit. *(Modified IRS Form 1040 and Schedule A)*.
- Employer purchase insurance. Insurance company informs the employer of the cost of each employee's policy to go on the W-2 form for tax credit.

Senior citizens as well as people who are in financial need would also benefit from HR-3462. *(HR 3472, p.4. ln. 16-19) (Chart 8)*.

> "(C) CERTAIN PREMIUMS UNDER SOCIAL SECURITY ACT TREATED AS PREMIUMS FOR BASIC HEALTH INSURANCE.—Premiums under part B of title XVIII of the Social Security Act shall be treated as premiums for basic health insurance.

4. HOW CAN HR-3472 HELP THE NEEDY ?

With private insurance the financial needy can get back into the mainstream of medical care. Private insurance will eliminate the problems of physicians and hospitals with the harassment of the paper work needed in government program coverage.

HR-3472 will also encourage people to make contributions to the needy/indigent who need medical insurance more than anyone else. *(Chart 8)*.

GIFT BENEFITS VERSUS WELFARE BENEFITS

Rep. Del Clawson, Ret.

GIFT OR TAX	AMOUNT	TO CHARITY OR GVRNMT	NEEDY RECEIVES
DIRECT GIFT	$1000	—	$1000
CHARITABLE ORGANIZATION	$1100	$100	$1000
CITY OR COUNTY	$1300	$300	$1000
STATE GOVERNMENT	$2000	$1000	$1000
FEDERAL GOVERNMENT	$4000	$3000	$1000

Schedule A - Itemized Deductions

Medical and Dental Expenses (not paid or reimbursed by insurance or otherwise) (See page 16 of instructions.)

1. Cost of Basic Insurance. Enter here and on Form 1040, line 38a under Credits

2. Additional Insurance Cost

3. Medical and Dental Expenses not covered by insurance
   - a. Doctors, dentists, nurses, etc.
   - b. Hospitals
   - c. Other (itemize - include hearing aids, dentures, eyeglasses, transportation, etc.

4. Total of 2 & 3

5. Subtract $500 exclusion — 500

6. Total medical and dental expenses. Enter here and on line 33.

5. HOW PRACTICAL IS HR-3472 ?

It has worked very well for me in my own organization, the Downey Urological Medical Group, even without the benefits of tax deductions. (Switching from a $100 deductible to a $2000 deductible has saved nearly $6000 in premiums which is designated to a pension fund if not used in $100 deductible for [illegible] self insurance for employees).

6. WHAT ARE SOME COST COMPARISONS ?

S-433 (Durenburger Bill)

- Average cost of insurance in all categories, is $1100 per year. ($1100 deductible for the employer; $1100 tax free benefit for the employee). *(S-433, p.8, ln. 1-9) Chart 4a)*.

HR-3472

- Average cost of insurance in all categories, for what appears to be similar insurance coverage, is $606 per year. *(Chart 4a)*. Even with a much more inclusive and expensive policy ($100 deductible), HR-3472 is still less, with an average cost of the insurance of $1042 per year. *(Chart 4b)*.

S-433
p.8

"(3) For months in the calendar year 1982, the indexed contribution amount shall be—

"(A) $50.00 with respect to coverage provided for the employee only;

"(B) $100.00 with respect to coverage provided for the employee and his spouse; and

"(C) $125.00 with respect to coverage provided for a family group consisting of the employee and his family (other than coverage

$1000 calendar year deductible

80% of first $10,000 and 100% thereafter per year

lifetime maximum of $1,000,000

Blue Shield of California Coronet -Plan 938-

AGE OF SUBSCRIBER	UNDER 30 YEARS	30 TO 44 YEARS	45 TO 54 YEARS	55 TO 64 YEARS
MALE	$185.40	$266.40	$450.80	$628.80
FEMALE	$215.40	$306.80	$523.80	$732.00
FAMILY OF TWO	$366.00	$535.86	$826.80	$1149.60
FAMILY OF THREE OR MORE	$505.70	$696.00	$988.20	$1322.40

Note: Average Cost of Insurance, Including All Categories:

[illegible] is $1100 per year — allowable for tax deduction.
HR-3477 ($1000 Deductible) is $606 per year — tax credit.
HR-3472 ([illegible] Deductible) is $1042 per year — tax credit and exclusion.

4a

$100 hospital deductible

80% of UCR fee for physician services

Blue Shield of California Coronet 365 -Plan 909-

AGE OF SUBSCRIBER	UNDER 30 YEARS	30 TO 44 YEARS	45 TO 54 YEARS	55 TO 64 YEARS
MALE	$354.80	$502.80	$703.80	$1014.60
FEMALE	$429.60	$603.00	$844.80	$1217.40
FAMILY OF TWO	$690.60	$969.00	$1356.00	$1956.00
FAMILY OF THREE OR MORE	$924.20	$1242.60	$1629.60	$2229.60

4b

7. HOW DOES HR-3472 COMPARE WITH PRO-COMPETITION BILLS ?

It has a low initial cost and therefore a small tax credit. (*Chart 4a*).

A large deductible concept encourages the prudent use of health care. It is more difficult to get a patient to choose less expensive outpatient studies for which they pay rather than go into a hospital with high costs paid by insurance than it is to get them to agree to necessary surgery.

HR-3472 has no complex regulations nor any punitive penalties on employers. (*Gebhart-Stockman, Sec. 234, p.137. ln.6-23, p.138 ln.1-17*).
(*See "Basic Pro-Competition Plans" Comparison*).
see Appendix

SEC. 234. CRIMINAL PENALTIES.

Any person who knowingly and willfully—

(1) makes or causes to be made any false statement concerning (A) the legal status of the person, (B) the person's marital status or number of dependents or other information relating to the person's actuarial category, (C) the person's place of residence; or (D) any other fact material to the person's eligibility for (or amount of the person's entitlement to) a healthcare contribution;

(2)(A) distributes a brochure concerning, or otherwise advertises, a qualified plan before the brochure has been filed pursuant to section 206(a),

(B) makes a material false statement concerning significant terms and conditions of a qualified plan in a brochure or advertising, or

(C) falsely states that a plan is a qualified plan under this Act;

(3) without authority converts to the person's own use any healthcare contribution or voucher for the benefit of another;

(4) submits a false request for payment to a qualified plan, to any deliverer, to an employer, or to the United States under the terms of this Act, or section 44F or 106 of the Internal Revenue Code of 1954;

(5) counterfeits or forges a healthcare voucher;

(6) makes a false statement or releases false information about any person or entity who is, was, or seeks to be a sponsor of a plan or a plan deliverer; or

(7) sells, transfers, or assigns an interest in a healthcare contribution or a healthcare voucher, or buys or accepts such transfer or assignment or interest except as authorized by this Act,

shall be fined not more than $10,000, imprisoned not more than five years, or both.

8. HOW CAN HR-3472 HELP LOCAL SAVINGS INSTITUTIONS ?

It will encourage ~~loans~~ Savings for protection against a large deduction in the basic health insurance plan. This is good for both the individual and the savings institution. (*Chart 9*).

Money will stay in the local community.

The whole process institutes and encourages savings habits, especially for those who really need such encouragement.

PROTECTION AGAINST SUDDEN EXPENSE

SAVINGS	LOAN, IF NEEDED, TO START
$1000	$1000
7.5 % INTEREST	9.5 % INTEREST
ONE YEAR $1077.50	MONTHLY PAYMENT
FIVE YEARS $1449.04	$91.25
	COST FOR ONE YEAR $1095
	($17.50 COST OVER INTEREST - INTEREST DEDUCTIBLE)

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9. WHAT IS HR-3472 NOT ?

- It is not a change of any current private, group or government insurance plan.
- It is not an excuse for new regulations or the establishing of a new bureaucracy to dictate the financing of health care insurance.
- It is not a punitive system for the control of employers-
- It is not compulsory.

APPENDIX

Basic "ProCompetition Plans"

1) **Each individual who (a) is a resident of the United States, and (b) is a citizen of the United States or a lawful resident alien...is eligible for a health care contribution. (Gephart - Stockman, HR 850, Sec. 101 (a) p. 24)**

Steps to Socialism	*Reduction of Cost and Regulation*
Encourages all citizens and legal residents to depend on the Federal Government and think medical care is right.	*Medical care is no more a right of anyone than is food, clothing and shelter. HR 3472 encourages all to use their own money for what is best for themselves before it goes to Washington and is "laundered" with 75% shrinkage. Grisham HR 3472, Sec. 2 (a) there shall be allowed as a credit against the tax...the amount paid by the taxpayer...as premiums for basic health insurance.*

2) **Forces, with Federal Government power, every employer to offer employees and their families a health insurance plan at the employers expense. The plan must meet qualifications and be approved by the Federal Government to be tax deductible.**

A feature, possibly of insignificance; but, strongly stressed by its promoters is that the employer must offer "options". These plans rest on assumption the individual is unable to act responsibly in his own selection of health care plan. Gephart states: "The employee tends to get more insurance than he actually needs". (Paraphrased) Adoption of any of these "Pro-Competition plans would allow the Federal Government to determine these answers and to determine how much insurance is right for each individual.	*Who's to judge how much insurance an indivual needs? What is the "proper amount" of coverage? What level of insurance provides a person with peace of mind as to his security? Last year I spent $638.21 on $33,999 worth of term life insurance - I didn't die, my wife and I could have had a nice little vacation with the premium.*
More regulation, larger bureaucracy, excess administrative expense for the employer. Fines and punishment for the employer (Gephart-Stockman, Sec. 234 p. 137, ln 6-23, p. 138, ln. 1-17) up to $10,000 fine and 5 yrs. in prison.	*HR 3472 allows the individual to choose any insurance he desires with a large deductible, a co-payment up to a reasonable amount and then 100% coverage (This outline suggested by Congressman Dan Rostankowski) specifically Grisham, HR 3472, Sec. 44 F, (a) (b) page 2, lines 12-15 and page 3, lines 1-13)*
"..... at the employers expense." He has no money except that which the employees have earned for him. For the Federal Government to approve all plans purchased by all employers would necessitate forming an horrendous new bureaucracy. "..... employer must offer options." He must hire or add hours of work to his accountants, comptrolers, lawyers, and medical consultants to advise him of the quality and cost of various options.	*Thus Congressman Rostankowski has suggested an outline of a basic insurance for which the government, with no new regulations, could give a tax credit and Congressman Grisham has made it specific. The insurance companies to be competitive would see to it their policies covered all the items now allowed for tax purposes. They would differ enough to keep the FTC off their backs for collusion.*

At one time I heard the Israelites had some 16,000 rules and regulations starting with the first admonition to not eat from the Tree of Knowledge and later the Ten Commandments. These regulations were all put into one 2000 years ago when Christ answered the young lawyer's question about the greatest law. It all boiled down to loving God and your neighbor as yourself. So it is with this. Instead of new laws and regulations as set forth in HR 850 and S 433, simplify the IRS 1040 and Schedule A forms and allow each person to be responsible for himself, his family and when able and wants to - his needy neighbor.

The Federal Government would have the authority to enforce employer compliance in offering an approved plan.

(Durenberger, S 433, Sec. 5, p. 14) More bureaucracy to determine what should be approved and then move to enforce it. The Federal Government would have unlimited funds to harass employers in all levels of citations up to the Supreme Court. Also in (Gephart - Stockman, Sec. 234, p. 137, ln. 6 - 23, pg. 138 ln 1-17)	*No force - HR 3472 is a voluntary Bill. The IRS has already set guidelines for those medical expenses for which deductions may be taken - from Aspirin vs. prescription drugs to at one time allowing CAT scans on fixed machines but not on mobile ones although the latter at times gave better resolution.*

3) **Every employer would be required to offer a minimum allowable contribution set by the Secretary of Health and Human Services. (Gephart - Stockman, HR 850, Sec. 201, p. 64 and Sec. 202, p. 67)**

Another onerous regulation - the cost of medical care varies markedly from one section of the country to another - even from one section of a county to another.	*In comparing the average cost of the basic insurance in HR 3472 and the average cost of a more comprehensive policy they were both less than the allowances for health care set forth in Durenburgers S 433. The allowance in S 433 doesn't take into consideration the*

age, sex or marital status of the taxpayer so would therefore reward the young single male and penalize the older, stable family.

4) A worker who chooses a plan with a premium which is less than the payment being made by his employer would be able to pocket the difference in cash-tax free. (Gephart - Stockman HR 850 - Summary)

More costly paper work for employer. May encourage employee to choose inadequate insurance coverage for his family.

HR 3472 allows the employee or self employed to be responsible for his own insurance and medical care. If the employees in a company should choose to receive in pay what the employer is now paying for their insurance that pay would be taxed. The employees could then ask the employer to arrange for a policy for each of them which would meet criteria for "Basic Health Insurance" (Grisham, HR 3472, Sec. 2 (a) p. 2, ln. 13-25 thru p. 3, ln. 1-13) He would then deduct the premium from their wages - a tax credit for the employee. The insurance company would have to furnish to the employer the invoice of the amount to be deducted from each employee's wage.

5) Citizens with lower taxable incomes would be issued cash vouchers. (Gephart - Stockman, HR 850, Sec. 106, p. 56)

This is reversing the President's desire to return those functions to the states which rightfully belong to the states.

HR 3472 allows and encourages each state to decide how to run its welfare program including new methods. At the present time there is a Bill being discussed by the California Legislature which would authorize the purchase of a $500 deductible policy for each person or family on welfare. The deductible portion would be worked out on an individual basis. Using the highest and lowest premium for such a policy by Blue Shield of Southern California the average cost is $802.00 per year or roughly $900/year less than the $1700 average payment for medical care for welfare patients in both 1978 and 1979. Should the state have to pay the entire $500 deductible for every patient there would still be a saving of about $400.

The tax credit in HR 3472 is refundable forward and back depending on the tax owed.

6) Any provisions of law, regulation, or administrative action of any state or unit of local government which prevents or impedes the reforms of the health care delivery system implemented, or the program created, under this Act is preempted as of this date of enactment of this Act. (Gephart - Stockman, HR 850, Sec. 302, p. 139).

Very definately Nationalizing the control of health care. This violates the U.S. Constitutional principle of individual responsibility and local self government.

HR 3472 does not take away any right of the State. It encourages states to use private insurance carriers to administer their welfare program at a lesser cost with equal or better quality of care.

7) Include catastrophic coverage with deductible. (Gephart - Stockman, HR 850, Sec. 204, p. 80) and (Durenberger, S 433, Sec. 2, p. 11).

Any deductible initially would be the target of politicians to be reduced to nothing. When this happens, the Federal Government would be responsible for everyones' medical care, regardless of income. Thus, compulsory socialized medicine would be in effect as in Eastern and Western European countries.

In HR 3472 no government has any control over the type of insurance purchased. The defined "Basic Insurance Policy" for which a tax credit would be given states ...100% coverage for any illness costing over $15,000. To lower that amount would increase the amount of tax credit. The members of Congress who want control of people are also the ones who feel higher taxes are the "right" of Congress because they know best how to spend our money; they would do nothing to increase the amount of tax credit of all the taxpayers.

Second front page

Southeast News
WEDNESDAY, SEPTEMBER 30, 1981 B-1

Dr. Bryan lobbies in Washington

By Pat McGreevy, Staff Writer

John Smith felt he was saving money and beating the system by not taking out a health insurance policy.

He was putting his money in the bank – not into the pockets of the insurance companies.

That is, until he discovered he needed major surgery that cost far more than he had saved.

John Smith, of course, is a fictional character, but his tragic plight is not.

A Downey doctor is leaving for Washington D.C. today to make sure there are fewer people in the future who find themselves facing out-of-reach medical costs without insurance.

Dr. J. Elder Bryan, a Downey urologist, came up with the idea eight years ago to provide a tax credit for those people who take out a basic health insurance plan.

The object of his idea was to give incentive to the 12 percent of Americans without medical coverage and to help those people who are already covered.

Bryan shared his idea with Dr. Jean Cram and Dr. Harold Wilkins, both of Downey; Dr. Frank Rogers of Whittier, and then-congressman Del Clawson.

The result was a bill, which when first introduced in 1975, didn't get the attention of liberal-minded Congressmen, according to Bryan.

The bill was introduced once more by Clawson and another time by Congressman Wayne Grisham.

All three times the bill fell on deaf ears in Congress and went nowhere.

Now Rep. Grisham has introduced the bill again, and it is currently in the Subcommittee on Health of the House Ways and Means Committee.

There it is being considered with several other bills that also propose reforms in the medical insurance field.

And so, for the second time since the bill's conception, Bryan has packed his bags to travel to Washington and testify before a congressional sub-committee.

This time, thoug. Bryan and Rep. Grisham give the bill more of a chance.

"He (Grisham) said it has a much better chance because it doesn't increase government regulation and bureaucracy," Bryan said.

"That's in line with the current way of thinking in Washington now."

The bill would offer persons who take out a $1,000 deductible health insurance plan a tax credit covering the whole of their premium.

Persons who want more coverage or a lower deductible would be able to take the credit and possibly deduct some other amount of the higher premium from their taxes.

The bill is in line with conservative thinking prevalent among the nation's lawmakers because it keeps insurance voluntary and simplifies the tax forms, according to Bryan.

"It doesn't force itself on anyone," Bryan said. "And we've worked out a simpler way of computing deductions and credits.

Some of the other bills, dubbed "competitive insurance" bills, would require an employer to offer employees several different insurance policies, he said.

Language used in the bills would mean each employer would have to hire an insurance consultant to keep from violating the bill's regulations Mmore bureaucracy would have to be created to monitor the employer's compliance, Bryan said.

He will take the stand in Washington at 9:30 a.m. Thursday as the only witness for Grisham's bill.

From there, Bryan hopes the subcommittee will give his bill the approval it needs to stay alive.

But even if the bill is not approved, Bryan has worked out a way the same principles can be applied between a bank and its customer.

The alternative approach involves banks loaning customers money to make premium payments on health insurance when needed, against the customer's interest on a savings acount.

A few people are currently trying Bryan's banking plan, but it is still experimental.

'Self insurance' health plan goes to Congress

By Paul McAfee, Staff Writer

Dr. J. Elder Bryan had an idea for affordable health insurance – the kind of plan just about everyone could handle.

With the prompting of a now-former Congressman, the Downey urologist drafted his thoughts in the form of a bill. The bill was introduced before three Congresses, but it never received a hearing.

Now, with a conservative trend rising to power in Washington, D.C., Bryan is hoping the fourth time will be a charm.

His health insurance bill was introduced before the 97th House of Representatives in April by Rep. Wayne Grisham (R-33rd Congressional District) as HR3472. Though the measure has not yet had a hearing in a subcommittee of the House Ways and Means Committee, Bryan hopes the committee's chairman, Rep. Dan Rostenkowski, will have some clout in convincing his committeemen to air the bill.

Bryan does have a few things going for him. For one, Rostenkowski himself provided a key definition for the measure. An added boon was a recent unsolicited endorsement for the measure from the California Medical Association.

Bryan, who is known around town as "J. Elder," is a former chief of medical staff at Downey Community Hospital. He manages a staff of urologists in addition to maintaining his own practice as head of the Downey Urological Medical Group.

When Bryan is not in town practicing his craft, he is out in the woods adding to his impressive collection of bear, moose, deer and caribou trophies.

Yet, even with all his busy activity, the Downey physician has taken time to consider the plight of those who have no health insurance.

"I've always been concerned with the cost of medical care," Bryan said. "I have empathy for the person who has no insurance."

Though health insurance plans abound in the marketplace, Bryan's plan for "self insurance" came to mind after he read a 1972 medical journal article that outlined all the key health insurance programs then before Congress.

"The article pointed out that all the key plans before Congress would actually add to the cost of health care – and they would ration health care," said Bryan.

"Looking over what he (the article's author) wrote, I found that he gave no alternative. All of the programs were going to give poorer care at more cost."

Bryan started encouraging people with no group health plan to purchase their own insurance.

His idea was to take health care out of the federal and state governments' hands and put it back into the hands of the individual.

"My whole philosophy is that the dictionary definition of insurance is to take care of the unexpected," Bryan said. "Other routine medical expenses should be paid for out of a person's own pocket, like they pay for food, shelter and clothing."

Bryan realized many families would find such out-of-pocket expenses for routine medical care – in addition to monthly premiums for an individual health plan – difficult to handle.

His plan, then, and the scope of his bill is to provide a refundable income tax credit as well as an equitable deduction system for those individuals who purchase a health plan for emergencies and pay out-of-pocket for other medical costs.

"The tax credit simply means people are using money from their own pockets for medical expenses and not going clear to Washington to receive medical care," Bryan said.

The doctor explained that as more and more control is given to the federal government in providing health care (paid for by tax dollars), the more such health care costs because of administrative and other off-the-top expenses.

If enough people bought their own health insurance plans, though, the federal government wouldn't have to spend as much in health care costs. Bryan feels the resulting tax savings should go back to the individuals who are providing for their own health needs.

It is perhaps easy to see why a liberal-oriented Congress would find Bryan's concept hard to swallow – or any concept, for that matter, that would tend to deplete the federal government's coffers.

But with a current tendency in Washington to cut back on the cost of big government, the time may have come for a consideration of the Downey doctor's plan.

Bryan first sat down with former Rep. Del Clawson to explain his theory. He drafted a bill at Clawson's urging, and the Congressman introduced it as HR10562 back in 1973.

After another introduction by Clawson, Bryan's health care tax credit plan has been introduced twice by Grisham.

Bryan emphasizes that his bill "does not change any current ways of financing medical care."

"It is an additional, optional plan," he said.

What the bill would do is amend the Internal Revenue Code of 1954 to provide the necessary tax advantages for those wishing to be "self insured."

Bryan feels the terms of the provi sion are not unrealistic. In order for a family or individual to qualify for the tax credit, they must have a health insurance policy which includes these provisions:

– No coverage for at least the first $1,000 of medical care expenses.

– Coverage for not more than 80 percent of medical care between $1,000 and $16,000.

– Total coverage for all expenses over $16,000.

The tax credit would be based on going rates for the cost of insurance in a person's given situation. For example, a male under the age of 30 would pay annual premiums of about $187 under a Blue Shield plan similar to the terms and conditions above, according to Bryan.

That person's tax credit would be $187.

A married couple between the ages of 45 and 54 would pay an annual premium of around $826 under the same plan. Their tax credit would be $826.

Bryan said that his bill also provides that all out-of-pocket expenses over an initial $500 exclusion would be deducted from a filer's adjusted gross income.

Bryan estimates that with a "self insurance" plan, people in the highest level of coverage (a family of three or more where the provider is from 55 to 64 years old) would pay a maximum of $4,000 for medical expenses in one year – and that with heavier than normal medical expenses. Under HR3472, that same family could deduct $3,500 from their gross income for tax purposes. Actual out-of-pocket costs to the family would amount to only $500, then – and the figure becomes correspondingly lower for "better" age groups and for those with fewer medical expenses.

Chairman JACOBS. The committee will reconvene its sitting.

I note that the dental people have come forward. However, there is one other witness prior to this panel. I would ask the dental people to just remain where you are, and we will ask Dr. Wurtz if he would come forward and present his testimony.

Dr. Wurtz, it was necessary to pass over you on the list. I believe you were not present earlier, but we would be happy to have your testimony now, and then we will go right into the other testimony.

STATEMENT OF KEITH G. WURTZ, M.D., ARLINGTON HEIGHTS, ILL.

Dr. WURTZ. Thank you, Mr. Chairman.

Honorable chairman, committee members, ladies and gentlemen, I am Dr. Keith Wurtz from Arlington Heights, Ill. I practiced general surgery there for 30 years.

As you are concerned about health care costs, so am I, and I am especially concerned about unnecessary costs. The reason there are unnecessary costs is, in part, because we have wrong-way incentives that tend to increase these costs. I don't have to tell you that, but this is the basic cause of this.

The patient, the physician, the hospital, the medical care insurance company all have reasons to profit from higher costs. There is a simple way to correct this, and I can present it to you. I am enthusiastic about it. I have worked for 10 years evolving this plan and I know if I can present it to you well you will be enthusiastic about it also.

The best way is a simple presentation of this part. Many Americans receive their health care benefits from their employer. It is taxed neither to the individual nor the employer. On the other hand, there is a significant group of people whose health care costs are paid for by themselves. These are the small shopowners, the self-employed farmers, and they pay for their health care benefits with after-tax dollars. This represents some 15 million people in the United States.

It is quite apparent that it is unjust to this group who pay for their health care with after-tax dollars compared with those who have their health care paid for with before-tax dollars.

A simple solution to this is to set up an individual health care account for these people, comparable to the individual retirement account, which was in the 1976 pension reform law and has been recently revised. This account would be funded, or could be funded, with untaxed dollars. This individual health care account could be deposited in a commercial bank, in a savings and loan, possibly an insurance company. Maybe we would want to have a specialized bank for this, I don't know, that would be a health care bank, and would have this type of deposit in it, comparable to the savings and loan industry where we have deposits for home building. These deposits could be insured by the FDIC, the Federal Deposit Insurance Corporation, so they would be protected.

How would this money in the health care account be spent? First, it would be for first-dollar health care coverage. This would be backed up by required insurance comparable to Blue Cross or Blue Shield. As the first dollar health care coverage amount increased, the insurance coverage would be proportionately decreased. If there was money left over, with its accumulated interest in this health care account, it could be used in several directions.

It might be used to fund a beginning insurance program for 18-year-old children. It might be used to fund backup health care for parents in the family because of limitations that are beginning to occur in medicare financing. This could be refunded to the individual, and he could spend it as desired if his health care account is at sufficient level.

How would this decrease health care costs, increase competition and improve quality? You gentlemen are reaching the age where you need to be concerned about the possibility of a cardiac, of a heart bypass operation. It will cost $20,000 to $25,000. If you were paying for this heart bypass operation out of your own health care account, you would be quite concerned about the quality. It is going to be like spending $20,000 for a new car. You don't go out and just buy a car. You bargain for it. You get the best quality that you can. If you can find somebody that will do your heart operation and do it well for $5,000 less, you are going to be very interested in it, because you are paying for your own operation out of your own individual health care account.

How would this influence a healthful lifestyle, as Chairman Jacobs asked the preceding speaker here a little bit ago. This would influence it in this manner, and I recite a little personal incident. When I was a small boy on a farm in Wisconsin, I went out in the snow without my overshoes and caught pneumonia. My family doctor, Dr. Breed, had to drive 7 miles, costing $7 with the horse and buggy, to treat me. My father said, "Keith, don't go out in the snow without your overshoes." Fifty-five years later, today when it starts to snow, I start looking for my overshoes. Now, if the father is paying for the health care out of his family bank account for the children, he is going to suggest that they eat a little more wisely so they don't get, or are not likely to get, that heart attack, and they are going to be concerned about drinking and using marihuana when they drive, because half of the fatal auto accidents and injuries in the country are caused by drunken drivers. I patch them up on Sunday morning at 4 a.m. when they have been injured. They will tend, if they have their own account, to live a better lifestyle, eat more wisely, smoke less, use less harmful drugs.

In summary, when somebody is spending his own dollars from his own bank account for his health care, he is going to bargain. He is going to put competition into the health care system. There is going to be less usage of hospital beds. That is unnecessary usage. When they cost $100,000 per room to build, it will lessen that cost. It will help remedy our nationwide nursing shortage. It will put savings deposits into our hard-pressed savings institutions, and it can be extended not only to self-employed people, but across the spectrum to an industry or a company that can deposit a health care account for an individual employee, or the Government, as you already knew, can extend this to medicare or even to medicaid.

This is a simple solution. I have worked on it myself for 10 years. I am enthused about it. It puts the consumer in an important position as well as the other health care segments. Can I answer any questions?

[An attachment to the statement follows:]

THE WURTZ INCENTIVE PLAN FOR IMPROVED QUALITY OF MEDICAL CARE AT LESS COST

THE PROBLEM

In 1970, Health Care Costs in the United States were estimated to be $200 per individual. In 1980, these costs had risen to $1,000 per man, woman and child; a total amount spent for Health Care of 220 billion dollars--almost 10% of the GNP. By 1990, it is estimated it may cost $2,000, and by the year 2000--$3,000 for each individual.

Health care costs have been increasing rapidly for many years. Some of the increased costs have been justified because of better quality, improved technology or greater usage. But major parts of medical costs not only are unnecessary but are wasted because of a lack of feeling of personal responsibility for these costs by the many health care segments receiving, providing or paying for such costs.

In other words, as far as the patient, physician, hospital, union welfare plan, medical insurance company and politician are concerned, "somebody else is paying the bill". Each health care segment has reasons to profit by higher health care costs without a corresponding improvement in quality.

Why are these costs rising so fast and faster than costs for other services and goods? Currently, health care has built-in incentives for increased cost.

Many of the remedies suggested to control costs are ineffective, inadequate or inapplicable. Cost containment acts and price controls do not promote long-term efficiency or education.

The best way to control costs is through incentive--not regulation. Health maintenance organizations have been shown to reduce health care costs 10% to 40% by reducing the number of admissions to and the length of stay in the hospital as the main source of savings. These HMO plans focus on direct financial incentives for the physician and the third-party payer. Most fail to provide any incentives for the other key members of the health care group--the patient, the hospital and the nurse.

SOLUTION FOR THE PROBLEM

Basic incentives can be given to the various health care segments to decrease unnecessary use and increase efficiency and quality, especially if the patient can profit by better education, more self-help programs, avoidance of unnecessary costs and unnecessary work absenteeism for health reasons.

Simply, The Wurtz Incentive Plan is a program in which the patient, his health care provider (physician, nurse and hospital) and the third party payer all have profit incentives for saving money in health care costs through better quality.

HEALTH CARE BANKS AND INDIVIDUAL HEALTH CARE ACCOUNTS

To accomplish these ends, I recommend the establishment of Health Care Banks comparable to savings and loan institutions for home financing. In the Health Care Bank, each individual or family could have an Individual Health Care Account, (IHCA), which might receive tax-free contributions in one of several ways and with which tax-free earnings might accumulate to an Individual's Health Care Account over a period of time up to a certain amount. There would be no ceiling on this account. This would be comparable to the Individual Retirement Act (IRA).

PAYMENTS FROM IHCA

The Health Care Account would be used to pay for health care costs in several of the following ways:

1. Initial medical and dental expenses up to the accumulated IHCA. (So called, first dollar costs.)
2. Back up medical and dental care insurance (like Blue Cross and Blue Shield) to be used until equal coverage is accumulated in the IHCA.
3. Above that cost level, the Health Care Account would be used to pay for catastrophic health care insurance, which might also be funded by government or industry.

DISTRIBUTION OF UNUSED HEALTH CARE ACCOUNTS

1. After payment of the above health care costs and accumulation of certain reserve amounts in the Individual's or Family Health Care Account, earnings from investment of the IHCA or actual

contributions could be accumulated tax free in the IHCA account or distributed and taxed to the individual if not needed for health care.

MECHANICS OF DEPOSITS AND SOURCES OF HEALTH CARE FUNDS

Where would funds for the Health Care Accounts be deposited?

1. Health Care Banks (a new institution?)
2. Commercial Banks (Health Care Division)
3. Corporate Health Care Funds
4. Union Health Care Funds
5. Medicare and Medicaid Payments could be made to an "individual's" account or maintained by the federal or state government.
6. Credit Unions, Insurance Companies

How would depositors be protected against Health Bank failure?

1. A branch of the Federal Deposit Insurance Corporation (FDIC) could insure IHCA against bank failure similar to current efforts in commercial banks and savings and loan institutions.

Where would tax-free funds for Health Care Accounts come from?

1. For privately employed individuals, tax-free contributions to the Individual Health Care Accounts might be made by the individual comparable to the IRA Pension Fund contributions.
2. Employers, governmental agencies, and corporations could make tax-free contributions each month into an employee's Health Care Account of an amount equal to what is contributed for the health care for that employee as well as his reimbursed time off from work for sickness purposes.

3. Union Health Plan funds could be deposited in Health Care Banks.
4. Medicaid and Medicare Funds could be applied to Individual Health Care Accounts.
5. Others--Military, Veterans, etc.

Let me outline how the Wurtz Incentive Program would stimulate these savings in many facets, and eventually, in all facets of medical care.

HEALTHFUL LIFESTYLE AND HEALTH EDUCATION INCENTIVES

I. The Patient has Incentives to be an Intelligent, Educated Health Consumer.
  A. Preventive Health Measures:
    1. Proper eating to maintain good health and thereby less expensive care.
    2. Avoid smoking and its harmful effects.
    3. Adequate, moderate exercise to:
      a. Strengthen the heart muscle and strengthen back muscles to avoid weak hearts and some back strains.
    4. Avoid excessive alcohol drinking.
      a. One half of fatal auto accidents involve a drunken driver.
      b. Many industrial accidents involve drinking on the job or drinking the night before--(1 in 14 industrial employees has a problem with alcohol).

Patient Education can be emphasized and accomplished because the IHCA could pay for educational programs for patients in nutrition, minor emergency care, self-help programs such as diabetic programs, breast self examinations, etc., with their own money.

IN SUMMARY

The Wurtz Incentive Program provides better health care at less cost:

Patients make money for themselves in their Individual Health Care Accounts by:

a) Better lifestyle

b) Less illness-related time off from work

c) More home care

Providers make more money by:

a) Better quality care

b) Less unnecessary care

c) More outpatient care

d) More home care

Payers save money by:

a) Less overall cost

b) Less absenteeism

Society gains a valuable new resource in individually accumulated bank deposits from previously wasted Health Care Costs benefiting each individual and society as a whole. Assume we had saved 10% of our health care costs in 1980, this would have amounted to 22 billion dollars.

Keith G. Wurtz, M. D.

Chairman **Jacobs**. Thank you very much, Doctor. Other members will be back after the vote. We will defer the questions. It strikes me if you had paid that $7 yourself you might wear your overshoes all the time, under your theory.

Dr. Griffiths, would you proceed, sir.

STATEMENT OF ROBERT H. GRIFFITHS, D.D.S., PRESIDENT-ELECT, AMERICAN DENTAL ASSOCIATION, CHARLESTON, ILL.

Dr. **Griffiths**. I am Dr. Robert H. Griffiths of Charleston, Ill., where I am engaged in the general practice of dentistry. I am here today as president-elect of the American Dental Association, which represents 140,000 members from throughout the country.

We have submitted to you a prepared statement which we would like to have made a part of the record, and I will merely summarize this morning for you.

Perhaps the problems that we see in the bills before you stem from, and are another indication of, the troublesome fact that national health programs and policies are sometimes developed without recognizing the essential differences and distinctions that exist between dental diseases, which are of virtual universal incidence, and other diseases, which are largely episodic. These differences are reflected in the independent dental care delivery system and the separate system for delivery of medical and hospital services. Nowhere are these differences more important than in dealing with general health insurance on the one hand and dental benefit plans on the other.

With respect to the latter, I should say that the ADA has supported private sector dental benefit plans from their inception over 25 years ago in the belief that they possess the capacity to increase the availability of care and consequently foster better dental health care in the United States. Experience has verified this belief.

With that brief background, I would like to discuss what we perceive to be the principal objective of these three bills, and indeed of the procompetition consumer choice concept; namely, to control the cost of health care by encouraging the public to accept a significant direct payment responsibility for this care.

I would like to review with you the applicability of this procompetition objective to dental benefit plans.

First, it should be noted that the conventional dental benefit plan model was developed and marketed competitively since 1954, unlike the hospital and medical plans, has been successful in maintaining the price sensitivity of subscribers and has avoided subscriber insulation from the need to consider the cost of treatment and the benefit expected from it. This has been accomplished in the conventional dental benefit model by employing cost-sharing elements similar to those called for in the procompetition legislation, such as copayments, deductibles, and annual limits.

Although coverage under dental plans increased by more than 1,000 percent, we went from 6.5 million people in 1967 to more than 75 million in 1981, dental care costs as measured by the Consumer Price Index increased during that same period by only 155 percent. This compares to 165 percent for all goods and services, 190 percent for physician fees, and 360 percent for hospital costs.

In light of the moderate behavior in dental care costs, it is our view that subjecting dental benefit plans to the provisions of procompetition legislation would not contribute to the ability of such legislation to achieve its objectives, inasmuch as dental plans have not proven to be a spur to inflation that hospital-medical insurance has been, at least in the view of proponents of the procompetition approach.

At the same time, the prospect of such inclusion is of grave concern to us because, in our view and those of major insurers and service plans, elements of these three bills, most tellingly those mandating individual selection of all health benefits and those providing the cash incentives to select minimum health benefits, would be destructive to the continuation of dental benefit plans as they now exist.

When and how regularly an individual will seek dental care is very largely a matter left to that individual's discretion. This discretionary aspect of dental care, then, combined with the absence of need to guard against the costly chance event necessitates that the dental benefit plans, in order to be priced attractively, be marketed on a group basis, not on the basis of a number of individual decisions within a group. By and large, elimination of the group decision process would result in the plan being accepted by only those contemplating extensive dental services. This circumstance, therefore, would cause adverse selection and increase the cost of the program per subscriber to the point that would render it unmarketable.

For these and other reasons we have amplified in our prepared statement, we strongly recommend that dental benefit plans be exempted from the restrictions, limitations, and incentives in the bills, which could end the growth of and potentially eliminate valuable and cost-effective dental benefit programs.

Thank you, Mr. Chairman. I would be glad to answer any questions.

[The prepared statement follows:]

STATEMENT OF ROBERT H. GRIFFITHS, D.D.S., PRESIDENT-ELECT, AMERICAN DENTAL ASSOCIATION, CHARLESTON, ILL.

I am Dr. Robert H. Griffiths of Charleston, Illinois where I an engaged in the general practice of dentistry. I am here today as President-Elect of the American Dental Association which represents 140,000 members from throughout the country.

We are especially appreciative of the opportunity to testify at these initial hearings on the bills that have been introducted "to stimulate competition in the financing and delivery of health care". The hearings give us an early chance to voice our concerns about the adverse effects on dental benefit plans that these well intentioned bills would have if enacted in their present form.

Perhaps the problems we see in the bills stem from, and are another indication of, the troublesome fact that national health programs and policies are sometimes developed without recognizing the essential differences and distinctions that exist between dental diseases (which are of virtual universal incidence) and other diseases (which are largely episodic). These differences are reflected in the independent dental care delivery system and the separate system for delivery of medical and hosptial services. Nowhere are these differences more important than in dealing with general health insurance on the one hand and dental benefit plans on the other.

With respect to the latter, I should say that the ADA has supported private sector dental benefit plans from their inception over twenty-five years ago in the belief that they possess the capacity to increase the availability of care and consequently foster better dental health care in the United States. Experience has verified this belief. People covered under these plans seek and receive more comprehensive dental care than the public in general. The plans afford many of our citizens the opportunity to enter into a program of continuing prevention-oriented professional care which is the one proven way to achieve lifelong sound oral health.

The Association seeks to improve access to comprehensive dental care for all Americans. The expansion of dental benefit plans is but one method. It is not the entire answer. But it is a proven method—people with benefits seek dental care with 20 percent more frequency than the public at large—and it is a practical answer—the one-third of the population with dental benefits account for nearly one-half of the total expenditure for dental care annually. (6.3 of 13.1 billion in 1979.) Further, it can be shown that the growth of dental prepayment has neither produced nor contributed to the inflationary effects upon the economy, sought to be addressed in H.R. 850, National Health Care Reform Act of 1981; S. 433, Health Incentives Reform Act of 1981, and S. 139, Comprehensive Health Care Reform Act.

With that brief background I would like to discuss what we perceive to be the principal objective of these three bills, and indeed of the pro-competition consumer choice concept, namely, to control the cost of health care by encouraging the public to accept a significant direct payment responsibility for this care. H.R. 850 states the need for achieving this objective most succinctly, "payment by third party payers for the preponderance of the health care delivered each year insulates patients, as well as physicians, hospitals and other deliverers of health care, from the need to consider the cost of treatment in addition to the medical benefit expected from it." the Senate bills would require employers subject to them to offer employees at least three health benefit plans, one of which would include catastrophic coverage only, presumably offered at a low annual premium.

H.R. 850 would ensure such employee options through a requirement that each employee announce the amount of his health care contribution, permitting employees then to purchase any qualified plan. Each of the bills would limit either the tax exempt contributions of employers to health benefit plans, the amount of such contributions that is tax exempt to employees or both.

Employees would be encouraged in these bills to select the least expensive health plan offered (and therefore the one that provides the greatest degree of cost-sharing for the employee) through systems of cash rebates representing the difference between the employer's contribution to the most comprehensive qualified plan and the premium for the plan chosen by the employee.

I would like to review with you the applicability of this pro-competition objective to dental benefit plans. First it should be noted that the conventional dental benefit plan model as developed and marketed competitively since 1954, unlike the hospital and medical plans, has been successful in maintaining the price sensitivity of subscribers and has avoided subscriber insulation from the need to consider the cost of treatment and the benefit expected from it. This has been accomplished in the conventional dental benefit model by employing cost-sharing elements similar to those called for in the pro-competition legislation. To illustrate, all major dental benefit plans require copayment by subscribers, either by specifying the percentages, (e.g., 10 percent for basic restorative services and 50 percent for major restorative services as in the auto industry program or 15 percent and 50 percent in the steel industry program) or by establishing fixed benefits (tables of allowances intended to approximate the percent of prevailing fees, e.g., 50 percent, as in the telephone program, or 75 percent, as in the coal industry program). Additionally, the conventional dental benefit model frequently utilizes deductibles. In major plans, such as those in the oil, railroad and coal mining industries, $50 per person annual deductibles are employed. In other plans, other amounts, usually not higher than $100 per person annually, are used. Further, all dental benefit plans impose annual maximum benefit amounts on covered individuals, (e.g., $1,000 in auto and steel, $750 in telephone).

Although coverage under dental benefit plans increased by more than 1,000 percent—from 6.5 million employees in 1967 to more than 75 million in 1981—dental care costs as measured by the Consumer Price Index increased during this same period by 155 percent as compared to 165 percent for all goods and services, 190 percent for physician fees and 360 percent for hospital costs.

In light of the moderate behavior in dental care costs, it is our view that subjecting dental benefit plans to the provisions of pro-competition legislation would not contribute to the ability of such legislation to achieve its objectives, inasmuch as dental plans have not proven to be a spur to inflation that hospital-medical insurance has been, at least in the view of proponents of the pro-competition approach.

At the same time the prospect of such inclusion is of grave concern to us because, in our view and those of major insurers and service plans, elements of these three bills, most tellingly those mandating individual selection of all health benefits and those providing the cash incentives to select minimum health benefits, would be destructive to the continuation of dental benefit plans as they now exist.

Dental prepayment, unlike hospital-medical insurance, does not represent insurance against substantial expenses incurred as the result of the occurrence of a chance event. Susceptibility to dental disease and the need for periodic preventive care is universal. When, and how regularly, a given individual will seek dental care, however, is largely a matter left to that individual's discretion. This discretionary aspect of dental care, then, combined with the absence of need to guard against the costly chance event, necessitates that dental benefit plans, in order to be priced attractively, be marketed on a group basis, not on the basis of a number of individual decisions within a group.

This approach distributes the underwriting risk over those members of the group who, in a given year, will receive extensive treatment, those who will receive preventive treatment only and those who will receive no treatment at all. Were each individual to decide whether or not to accept dental benefits, it would be a relatively simple matter for him to determine his likely dental expenditures for the forth-coming year and accept the plan only if those likely expenditures exceeded the premium cost to him. By and large, this would result in the plan being accepted only by those contemplating extensive dental services, a circumstance that would because of adverse selection increase the cost of the program per subscriber to a point that would render it unmarketable.

Were this to occur, it is our opinion that the nation would lose a significant force motivating a substantial segment of the public to achieve improved oral health through regular dental visits and sound home care habits. We believe the dental prepayment industry has demonstrated its capacity to improve access to comprehensive dental care by the fact that, according to representatives of major carriers of dental benefit plans, about 60 percent of covered individuals visit the dentist in a given year, whereas 49 percent of the population in general do so. Moreover, in 1979, the one-third of the population with benefits accounted for 49 percent of the annual dental care expenditures, divided about equally between monies paid directly by patients and benefits paid by insurance firms, service plans and other third parties. Again, this improved access to comprehensive care has been achieved for the population without diminishing its interest in the services being prescribed, their necessity and their cost.

It is our view, then, that dental benefit plans are demonstrably different from hospital-medical insurance plans in their design, intent and effect on the economy. These plans already are effectively addressing the concerns which have stimulated interest in the pro-competition bills. They ensure a continued positive effect upon the oral health of the nation.

In the final analysis, we believe strongly that it would be unwise public policy from the health standpoint and from the economic standpoint to enact legislation that would deter people from seeking and receiving preventive dental care, as we are convinced the pending bills would do.

For these reasons we strongly recommend that dental benefit plans be exempted from the restrictions, limitations and incentives in the bills which could end the growth of, and potentially eliminate valuable and cost effective dental benefit programs.

As a final comment I would like to refer to the provisions in H.R. 850 which would preempt various state and local laws which relate to the delivery of health care services. We are particularly concerned with provisions to preempt laws pertaining to the licensure of individuals who provide health services and to the duties which can be performed by various types of health care personnel. State licensure and similar laws have been enacted to protect the public health by assuring that individuals who provide specific health care services are in fact qualified to do so. While the preemption language in the bill is somewhat vague we believe it can only lead to the potential of individuals providing care which they are not qualified to provide. We have similar concerns with other elements of the preemption provisions. This authority of the states should not be preempted and we strongly oppose these provisions in that bill.

At this time we would be pleased to answer any questions you may have.

Mr. **GEPHARDT**. Thank you, Dr. Griffiths.

I would like to ask the representatives of the dentists what kind of a separate cap are you speaking of that would be established? You all understand that under many of the bills, there is a cap on the amount that can be excluded from an individual's income. Are you suggesting that we establish a separate cap for dentistry alone? Is that the idea?

Dr. **Stephens**. It so happens that Dr. Griffiths, who represents the American Dental Association, does not represent the Academy of General Dentistry, the group asking for a separate cap. I will be speaking for a group of general dentists who will be asking for a separate cap, and perhaps after I give my statement I can then clarify your questions. We have only heard one witness.

Mr. **Gephardt**. I am sorry, I apologize.

Mr. **Gradison**. Perhaps we should move through the prepared testimony of the panel and then come back to questions. Our next witness will be Dr. Paul A. Stephens, chairman of the council on legislation of the Academy of General Dentistry.

STATEMENT OF PAUL A. STEPHENS, D.D.S., CHAIRMAN, COUNCIL ON LEGISLATION, ACADEMY OF GENERAL DENTISTRY, ACCOMPANIED BY JOHN T. TUCKER AND MIMI WANG FEINSTONE

Dr. **Stephens**. Mr. Chairman, members of the subcommittee, I am Dr. Paul Stephens. I practice general dentistry in Gary, Ind. I appear before you today as chairman of the council on legislation of the Academy of General Dentistry. The academy represents more than 22,000 practicing general dentists who are devoted to continuing education. With me today are John T. Tucker and Mimi Wang Feinstone of the academy's Washington office.

I shall also be reading excerpts from the prepared testimony, the full text of which you have.

We applaud the intent of any proposal designed to contain costs, while broadening access to high quality health care. Dentists, in their total commitment to preventive services, have done much to further cost containment in health care. But we are seriously concerned that the current proposals, by excluding dentistry, will force our hard-working citizens to choose between medical care and dental care and encourage the public in its misguided belief that dental care is discretionary, and that tooth loss is the unavoidable and natural result of aging.

For the past 20 years, general dentists have focused much of their attention on three major issues: cost containment; prevention; and promoting acceptance of dental prepayment mechanisms.

We fear that the proposals will reverse positive progress made by general dentists in these areas, resulting in: increased dental costs; reduced growth in dental prepayment; reduced access to dental care among those citizens in need of assistance with dental expenses; and reduced motivation to seek preventive care.

General dentists have devoted themselves to cost containment, and recent Health Care Financing Administration statistics bear out the success of our commitment. The share of the health care dollar expended for dental services has remained relatively stable since 1965. Americans continue to spend approximately 6.4 percent of their health care dollars on dentistry, in spite of a 28-percent increase in dental visits between 1968 and 1978.

The end result of fiscal prudence on the part of general dentists has been to hold the rate of inflation on dental care costs far below inflation on other health care services, to hold those costs below even the rate of inflation on food. For the 12 months ending with June 1981, dental care costs increased by only 8.3 percent, while physician services increased by 10.5 percent, hospital rooms increased by 14 percent, medical care by 10.1 percent, and food by 8.6 percent.

An integral element in the cost containment efforts of general dentists has been promoting acceptance of the benefits of preventive dental care in reducing the need for costly corrective care in the future. As a result of these efforts, 92 percent of the public believes that it is possible that preventive dental care can reduce future dental costs, and only 17 percent of the public believes that dental care is only for corrective treatment.

The measures before you now would thwart the efforts of general dentists to bring about such a positive behavioral change. Nearly 85 percent of the public now says that dental insurance is needed to help pay necessary dental expenses. By excluding dentistry from required covered services under these measures, and by failing to provide employers with tax credits for dollars paid in dental benefits, employers will opt out of dental benefits, and the American public will opt out of preventive dental care.

We strongly believe that the cause of cost containment in dentistry can advance only if the cause of preventive dentistry advances. And we are not alone in this belief. Insurance carriers are committed to preventive dentistry as a means of cost containment by virtue of their own experience. Many dental plans already provide for a gradual reduction in co-insurance payments when regular preventive care is sought, while others waive co-insurance and deductibles altogether with regard to preventive treatment. It is the experience of these insurance carriers that preventive dental care means cost containment.

Nor is including dentistry under a cap that also covers medical benefits the answer to this problem. Again, despite essentially positive attitudes about the need for dental care, only 53 percent of the public regularly seeks that care. General dentists believe that this low rate of utilization is directly related to the extent to which the public perceives itself at risk from dental disease. That susceptibility to dental disease is universal is undeniable. Yet only 12 percent of the public perceives itself as very susceptible to dental disease.

As a result, if dentistry is included under the same cap as medicine, our citizens will be inclined to choose coverage only for perceived risks and decline coverage for ills that they do not perceive as risks. They will decline the opportunity to prevent dental disease in favor of cash in hand. Both the cause of cost containment and the health of the American public will suffer from such a choice: our citizens will continue to spend millions of unnecessary dollars on costly corrective dental treatment that is the inevitable result of dental neglect, and millions of Americans will suffer the needless pain and loss of function that is the inevitable result of failure to seek preventive dental care.

Finally, I would like to express the concerns of general dentists as to the impact of this proposed legislation on the growth of dental prepayment plans. Dental prepayment has been successfully marketed since 1954. Today, 75 million Americans are covered by such programs, and 85 percent of the public says dental insurance is needed to assist with necessary expenses.

Because the risk of dental disease is universal, because dental insurance is designed to assist in the payment of regular, necessary expenses, rather than protect individuals from the financial burdens of unexpected health care emergencies, dental prepayment is affordable only when it is marketed to large groups.

Exclusion of dentistry from required services and failure to extend tax credits to employers that provide dental benefits presents to general dentists a frightening specter: Employers will cease to provide dental benefits, because it will no longer be profitable to do so; insurance carriers will cease to market dental prepayment, because employers will cease to establish the large groups required to make low-cost dental insurance feasible; and the 65 percent of dental users who say they now have dental insurance will find themselves without the coverage that makes regular dental care affordable. The implications for cost containment and dental health in America are clear and threatening.

Again, including dentistry in a cap that also provides for medical benefits is simply not the answer. Given the choice between tax-free cash and coverage for a risk that the public does not yet perceive, we believe that Americans will, understandably, choose cash in hand. Enrollment in dental groups will drop, and the cost of dental prepayment will skyrocket.

Further, Americans will be inclined to enroll in dental prepayment programs only when the need for corrective treatment and its attendant costs render premiums more attractive than tax-free rebates. And, most important, from both the standpoint of cost containment and public health—the need for preventive care, the cornerstone of modern dental treatment, will be sacrificed in favor of cash in hand.

Only with provision of tax credits for dental benefits and a separate cap for dental coverage will dental prepayment continue to grow. Dental care costs can be contained because dental disease can be prevented—if employers are provided with incentives to offer dental benefits, and if the public is provided with incentives to seek preventive dental care. We urge you to revise these proposals to include dental care among the health benefits required and to provide a separate cap for dental services.

[The prepared statement follows:]

STATEMENT OF DR. PAUL A. STEPHENS, CHAIRMAN, COUNCIL ON LEGISLATION, ACADEMY OF GENERAL DENTISTRY

Mr. Chairman, Members of the Subcommittee, I am Dr. Paul A. Stephens. I practice general dentistry in Gary, Indiana. I appear before you today as chairman of the Council on Legislation of the Academy of General Dentistry. The Academy represents more than 22,000 practicing general dentists who are devoted to continuing education. With me today are John T. Tucker and Mimi Wang Feinstone of the Academy's Washington office.

I comment on the legislation now before you from the perspective of general dentists, reflecting the views of general dentists as to how the proposed legislation will impact our patients, our practices, and the dental health of the United States.

We applaud the intent of any proposal designed to contain costs, while broadening access to high quality health care. Dentists, in their total commitment to preventive services, have done much to further cost containment in health care. But we are seriously concerned that the current proposals, by excluding dentistry, will force our hard-working citizens to choose between medical care and dental care and encourage the public in its misguided belief that dental care is discretionary, and that tooth loss is the unavoidable and natural result of aging.

For the past 20 years, general dentists have focused much of their attention on three major issues: cost containment; prevention; and promoting acceptance of dental prepayment mechanisms.

We fear that the proposals will reverse positive progress made by general dentists in these areas, resulting in: increased dental costs; reduced growth in dental prepayment; reduced access to dental care among those citizens in need of assistance with dental expenses; and reduced motivation to seek preventive care.

General dentists have devoted themselves to cost containment, and recent Health Care Financing Administration statistics bear out the success of our commitment. The share of the health care dollar expended for dental services has remained relatively stable since 1965. Americans continue to spend approximately 6.4 percent of their health care dollars on dentistry, in spite of a 28 percent increase in dental visits between 1968 and 1978.

The end result of fiscal prudence on the part of general dentists has been to hold the rate of inflation on dental care costs far below inflation on other health care services, to hold those costs below *even* the rate of inflation on food. For the 12 months ending with June, 1981, dental care costs increased by only 8.3 percent, while physician services increased by 10.5 percent, hospital rooms increased by 14 percent, medical care by 10.1 percent, and food by 8.6 percent.

General dentists comprise three quarters of the practicing dentists in the United States; thus, we believe that the lion's share of credit for successfully retarding the rate of inflation on dental services accrues to general dentists. And, as general dentists, we question the need for measures directed at cost containment that may sacrifice the health and welfare of our patients.

An integral element in the cost containment efforts of general dentists has been promoting acceptance of the benefits of preventive dental care in reducing the need for costly corrective care in the future. As a result of these efforts, 92 percent of the public believes that it is possible that preventive dental care can reduce future dental costs, and only 17 percent of the public believes that dental care is only for corrective treatment.

Nonetheless, during the 12 months from January 1, 1979 to January 1, 1980, only 53 percent of the American public sought dental treatment, and only about half of those who went to the dentist during that period sought preventive care. Our conclusion from this data is that, while the American public now holds positive attitudes about the benefits of preventive treatment, thus far, general dentists have been unable to convert these positive attitudes into positive behavior.

The measures before you now would thwart the efforts of general dentists to bring about such a positive behavioral change. Nearly 85 percent of the public now says that dental insurance is needed to help pay necessary dental expenses. By excluding dentistry from required covered services under these measures, and by failing to provide employers with tax credits for dollars paid in dental benefits, employers will opt out of dental benefits, and the American public will opt out of preventive dental care.

We strongly believe that the cause of cost containment in dentistry can advance only if the cause of preventive dentistry advances. And we are not alone in this belief. Insurance carriers are committed to preventive dentistry as a means of cost containment by virtue of their own experience. Many dental plans already provide for a gradual reduction in co-insurance payments when regular preventive care is sought, while others waive co-insurance and deductible altogether with regard to preventive treatment. It is the experience of these insurance carriers that preventive dental care means cost containment.

Nor is including dentistry under a cap that also covers medical benefits the answer to this problem. Again, despite essentially positive attitudes about the need for dental care, only 53 percent of the public regularly seeks that care. General dentists believe that this low rate of utilization is directly related to the extent to which the public perceives itself at risk from dental disease. That susceptibility to dental disease is universal is undeniable. Yet only 12 percent of the public perceives itself as very susceptible to dental disease.

As a result, if dentistry is included under the same cap as medicine, our citizens will be inclined to choose coverage only for perceived risks and decline coverage for ills that they do not perceive as risks. They will decline the opportunity to prevent dental disease in favor of cash in hand. Both the cause of cost containment and the health of the American public will suffer from such a choice: our citizens will continue to spend millions of unnecessary dollars on costly corrective treatment that is the inevitable result of dental neglect, and millions of Americans will suffer the needless pain and loss of function that is the inevitable result of failure to seek preventive dental care.

Therefore, if the proposals now under consideration are to achieve cost containment and protect the dental health of the American public, tax credits must be extended to employers that provide badly needed dental coverage, and a separate cap must be provided for dentistry that makes it financially advantageous to our citizens to avail themselves of regular preventive dental care.

Finally, I would like to express the concerns of general dentists as to the impact of this proposed legislation on the growth of dental prepayment plans. Dental prepayment has been successfully marketed since 1954. Today, 75 million Americans are covered by such programs, and 85 percent of the public says dental insurance is needed to assist with necessary expenses.

Because the risk of dental disease is universal; because dental insurance is designed to assist in the payment of regular, necessary expenses, rather than protect individuals from the financial burdens of unexpected health care emergencies, dental prepayment is affordable only when it is marketed to large groups. Exclusion of dentistry from required services and failure to extend tax credits to employers that provide dental benefits presents to general dentists a frightening spectre: employers will cease to provide dental benefits, because it will no longer be profitable to do so; insurance carriers will cease to market dental prepayment, because employers will cease to establish the large groups required to make low cost dental insurance feasible; and the 65 percent of dental users who say they now have dental insurance will find themselves without the coverage that makes regular dental care affordable. The implications for cost containment and dental health in America are clear and threatening.

Again, including dentistry in a cap that also provides for medical benefits is simply not the answer. Given the choice between tax free cash and coverage for a risk that the public does not yet perceive, we believe that Americans will, understandably, choose cash in hand. Enrollment in dental groups will drop, and the cost of dental prepayment will skyrocket. Further, Americans will be inclined to enroll in dental prepayment programs only when the need for corrective treatment and its attendant costs render premiums more attractive than tax free rebates. The result will be constant fluctuation in dental group size, rendering it impossible for prepayment carriers to effectively calculate actuarial tables. And—most important from both the standpoint of cost containment and public health—the need for preventive care, the cornerstone of modern dental treatment, will be sacrificed in favor of cash in hand. Only with provision of tax credits for dental benefits and a separate cap for dental coverage will dental prepayment continue to grow, to help advance the cause of preventive dentistry and to save millions of hard-earned dollars now spent on corrective dental treatment.

In conclusion, general dentists take pride in the fact that 85 percent of the public looks upon us as qualified professionals, that nearly 75 percent of the public believes that we treat people as people, rather than ailments, that 61 percent of the public believes that dentists are worth what they charge, and that 95 percent of the public is satisfied with the chairside manner in our offices. These are our successes.

But our pride of accomplishment is diminished by our concern that, despite these positive attitudes, dental care utilization is restricted to 50 percent of the American public, and that even among regular users of dental care, less than 12 percent consider themselves very susceptible to dental disease.

Until such time as the American public perceives the risk of dental disease, any proposal that would potentially reduce the availability of dental prepayment and discourage the public from seeking regular preventive care will have devastating effects on the health of the American public, and will irreparably damage the efforts of those who seek to contain health care costs.

Dental care costs can be contained because dental disease can be prevented—if employers are provided with incentives to offer dental benefits, and if the public is provided with incentives to seek preventive dental care. We urge you to revise these proposals to include dental care among the health benefits required and to provide a separate cap for dental services.

Thank you.

Mr. Gradison. Thank you, Dr. Stephens. We will now hear from Dr. Erik D. Olsen, chairman of the Government Programs Committee, Delta Dental Plans Association.

STATEMENT OF ERIK D. OLSEN, D.D.S., CHAIRMAN, GOVERNMENT PROGRAMS COMMITTEE, DELTA DENTAL PLANS ASSOCIATION, AND PRESIDENT, CALIFORNIA DENTAL SERVICE, ACCOMPANIED BY PATRICK GRIBBEN, PRESIDENT, DELTA DENTAL PLAN OF MICHIGAN

Dr. OLSEN. Thank you, Mr. Chairman. I am Dr. Erik D. Olsen, president of California Dental Service, the Delta Dental Plan of California, and chairman of the Government Programs Committee. I have with me Mr. Patrick Gribben, president of Delta Dental Plan of Michigan. Although I will summarize, I would appreciate having my entire written testimony entered in the record.

Delta Dental is the Nation's oldest and largest prepayment organization today covering some 16 million Americans. We are proud of the role we have had in developing this relatively new segment of health care delivery into a cost-effective and preventive-oriented system. Although dental care was first thought to be uninsurable, Delta has developed program designs that have proven cost effective. These include preventive-oriented copayments, deductibles, and program maximums.

I think my colleagues on the panel have elaborated to a sufficient extent on the fact that dental disease is a widespread problem today. Suffice it to say that over the last 20 years, during the growth of prepayment, we have gone from two-thirds of the people who did not visit a dentist annually to now where over one-half seek care, a significant improvement during the time when dental prepayment came to cover these 75 million Americans.

It is the view of Delta Dental Plan that dental benefit programs for employees should be excluded or exempted from the provisions of the procompetition legislation currently under consideration in the Congress. This position, which I elaborate on in my written testimony, is based on the following reasoning:

First, that such inclusion is unnecessary on the basis that effective cost containment mechanisms presently exist in prepaid dental programs.

Second, that dental costs are not a significant or uncontrolled factor in health care expenditures.

Third, that dental prepayment is so vastly dissimilar from hospital and medical surgical benefit programs in size, structure, and operations that it must be considered unique.

Moreover, it is the contention of Delta that the inclusion of dental benefit programs in enacted legislation would, in fact, have a reverse or opposite effect of the legislation's intent resulting in the following: A total undermining of the present dental delivery and financing system as a result of adverse selections in groups seeking dental benefit programs; the concomitant escalation of costs that would make purchase of dental benefit programs prohibitive; and a system that would discourage patients from seeking preventive services, which, of course, in turn would lead to greater expenditures for more extensive treatment later.

In my brief time, let me cite a couple of facts to support this position. Cost containment mechanisms not only exist in dental prepayment, they also work. Most significantly, at the same time there was a rapid growth in dental payment programs, costs did not escalate. During the last decade, while the number of people covered more than doubled, dental fees not only rose considerably less than health services, but 10 percent less than all services. Thus, a major goal of the proposed legislation is already being accomplished, that of consumer sensitivity to health care costs. The design of dental programs, with cost-sharing mechanisms, such as copayments, deductibles, and maximums remind the consumer that health care is not free, that alternatives are possible, and economic consideration should enter health care decisions.

Dental program design has done this, and at the same time encourages the consumer to use preventive services, and provides the consumer with adequate protection against major expenses.

We share your concern with rising health care costs, but we believe that your efforts should not include dental benefit programs. Available data shows that while $235 billion was expended in 1980 on health care, only $3.1 billion was paid through dental prepayment programs or less than 2 percent of total health expenditures.

Earlier I stated that this proposed legislation might have the opposite or reverse effect than that intended. The key reason is that the legislation would cause adverse selection; I know we have heard that term a number of times through the last couple of days. It has been characterized as being "frustrating" adverse selection; but I think in the dental benefit programs you might call it "destructive" adverse selection. The very predictable and elective nature of dental care has mandated that dental prepayment be offered only to groups, usually of 25 or more people. Individual selection has been shown to be actuarially unsound and program costs escalate substantially.

Finally, this adverse selection would also tend to deemphasize prevention. While dental benefit programs have prevented an escalation of costs, they have been preventive oriented. A 7-year study of people covered by dental prepayment programs has shown that the costs per patient have actually declined by 15 percent over those years, when adjusted for inflation; this is eloquent testimony to the cost-effective nature of dental prepayment design and the preventability of dental disease.

In summary, the prepaid dental care industry has and continues to support and promote the objectives to which pro-competition is addressed. Dental prepayment programs have successfully contained dental care costs while increasing accessability of the public to that care. As a result, the quality of care delivered and the improvement in the oral health of the Nation have been increased.

It is the position of Delta Dental Plan that the exemption of dental programs from any legislation similar to that proposed in the various procompetition bills would not diminish in the least the capacity of such legislation to control health care costs, and would insure the continued positive effects of prepaid dental programs on the oral health of the Nation.

Delta believes that the inclusion of dental benefit programs in the proposed legislation is unnecessary, because effective cost mechanisms are already an integral part of its programs. Dental care costs are not a significant nor an uncontrolled factor in these expenditures, and dental benefit programs are by nature an operation totally different from hospital and medical surgical programs.

The impact of the proposed legislation would be likely to increase, not decrease, the cost of dental care, and would reduce the likelihood of a large segment of the population now receiving care to attain a health maintenance level through access to preventive services. In our view, this would be inflationary and would achieve quite the opposite effect than intended.

It is our sincere belief, therefore, that the best interests of the American public would be served by exempting dental benefit programs from the provisions of the proposed legislation. Thank you, and I would be happy to answer questions.

[The prepared statement follows:]

STATEMENT OF ERIK D. OLSEN, D.D.S., CHAIRMAN, GOVERNMENT PROGRAMS COMMITTEE, DELTA DENTAL PLANS ASSOCIATION, AND PRESIDENT, CALIFORNIA DENTAL SERVICE

Mr. Chairman, I am Dr. Erik D. Olsen, President of California Dental Service, the Delta Dental Plan of California, and Chairman of the Government Programs Committee of Delta Dental Plans Association. Delta Dental Plans Association is the national coordinating agency for the country's not-for-profit dental service corporations. The Delta Dental Plan system is the nation's oldest and largest dental prepayment organization and today covers an estimated 16 million Americans nationwide under both private and publicly funded programs.

DELTA DENTAL PLANS

While historically formed and supported by the dental profession, Delta Dental Plans are separate, autonomous prepayment organizations under the jurisdiction or regulation of state insurance commissioners or attorneys general. As a result of Delta's support by the dental profession, and unique contractual relationships with participating dental practioners, Delta Plans provide true "service" benefits, in contrast to indemnity payments, for the cost of treatment to covered subscribers.

An estimated 68,000 dentists, close to two-thirds of the approximately 100,000 active practitioners in the United States, are presently contracting participants in Delta programs.

Delta Dental Plans design their programs to provide maximum dental care benefits to subscribers at reasonable cost to the program purchaser and the covered subscriber. Since all Delta Plans are not-for-profit, no portion of the benefit dollar is held for dividends to shareholders. All funds received by Delta Plans, therefore, are used to pay for services rendered to covered subscribers and eligible dependents and the administration of the program. Dental consultants are designated by the Plans to review the necessity, appropriateness and adequacy of care provided by participating dentists.

Delta Plan administrative techniques, which have evolved from a first-hand awareness of the "elective" nature of most dental treatment, embody a cost containment concept most visible in such program design elements as deductibles, copayments and maximums, and in the determination of covered benefits by Plan dental directors and consultants. Basing their claims processing policies on professionally accepted standards of dental care, Delta Plan dental directors and consultants are able to effectively control areas of program over-utilization and potential abuse.

Moreover, the Delta system successfully pioneered such innovative cost containment and quality assurance procedures as reimbursement based on verified fees of its participating dentists, predetermination of proposed treatment, and pre- and post-treatment review of proposed or completed care.

Under the terms of the agreement with the Delta Plan, a participating dentist agrees to be bound by certain uniform requirements established by the Plan's Board of Directors. In addition, the participating dentists agree to accept direct payment from the Plan and not seek additional compensation from the covered subscriber other than appropriate copayments or other shared obligations under that patient's particular group program. The dentist also agrees to cooperate with the state or local peer review committees.

DENTAL DISEASE AND PREVENTION

Dental disease is the most extensive health problem in the United States today, and is almost pandemic with respect to its occurrence in the population. Dental diseases are not self-healing and cannot be cured by professional advice or medication alone. Without treatment, dental diseases continue their damage and proceed to become more severe. Such oral health problems have become so widespread that some people apparently have accepted tooth loss and other complications of dental disease as inevitable.

A major difference between the public's view of medical and dental problems is that most people fail to relate oral disease to their general systemic health and well-being. Frequently there is a tendency to accept dental disease complacently because of the undramatic nature of most dental problems in their early stages. This casual acceptance of dental disease contributes greatly to the postponement of treatment.

Although the cumulative dental health problems of this nation are huge, remarkable progress can be made, and has been made, if the existing knowledge and science of dental treatment are put to use and made available to our citizens. The most economic and efficient way to improve the nation's oral health is to prevent dental disease. From the economic standpoint, regular and routine preventive care and maintenance is the most cost-effective and efficient way to overcome both the human suffering and the hours of productive work time lost through the disabilities caused by the poor oral health of countless millions of Americans.

For example, data from a Health Interview Survey of the U.S. Department of Health, Education and Welfare, now Department of Health and Human Services, revealed that there are 2.5 acute dental conditions per 100 persons annually. These conditions result in an average of 9.6 days of restricted activity and an average of 3.4 days of home disability per 100 persons each year. By projecting these statistics nationally, the annual loss of work hours due to dental disease can be estimated. To use federal employees as an example, it can be stated that of the 2.7 million federal employees, an estimated 67,500 suffer from acute dental conditions every year. The dental disease would result in restricted activity for 259,200 days, or 2.1 million person hours, and would also account for 126,900 days of absence from work annually.

This would indicate that the Federal Government, the nation's largest employer, is losing 3 million or more productive work hours each year as the result of dental disease. If extended to the entire American work force, the impact of untreated dental disease on productivity can be viewed as no less than staggering.

If one includes in this consideration other important aspects associated with the failure to receive needed care, the economic impact is even greater. Included would be the personal and social costs of dental neglect and the loss of quality of life brought about by oral disease. Even without these indirect cost considerations, there is substantial support for the economic efficiencies made possible by disease prevention through regular and routine health care.

In recent years it has become widely accepted by health care professionals and economists that prevention might be used, not only to improve the health of Americans, but also to help contain the cost of their health care.

The basic idea is a simple one: relatively low cost investments in disease prevention and health education will prevent or postpone the onset of illness and disability requiring more expensive treatment. Thus, prevention succeeds as a cost containment mechanism if the dollars saved in future years exceed the current cost of the prevention effort, whether the savings be due to expenditures completely avoided or only delayed.

The experience of recent years in dental care through programs of preventive treatment and the mechanism of dental prepayment and insurance has been perhaps the most dramatic example of the principle of prevention in action.

Once thought "uninsurable," dental care has now joined hospital and medical/surgical coverage as a standard benefit in the employee benefit package in virtually all segments of the American work force. Dental prepayment has enabled and/or motivated a far greater number of people to obtain dental care than would otherwise have been possible. It has been demonstrated frequently that a larger proportion of covered patients regularly seek dental care than do those without dental benefit programs.

Less than 20 years ago, nearly 65 percent of the population did not visit the dentist during a given year. Today, more than half of the population has one or more dental visits annually. Two factors have been critical to this improved picture: the emphasis on preventive measures, health care education and early diagnosis and treatment in the dental office and the growth of prepaid dental benefit programs to the point where 75 million Americans have dental care coverage today.

VIEW OF DELTA DENTAL PLANS ASSOCIATION ON PROPOSED "PRO-COMPETITION" LEGISLATION

It is the view of the Delta Dental Plans Association that dental benefit programs for employees should be excluded or exempted from the provisions of any "pro-competition" legislative proposals under development or presently under consideration in the Congress. This position, which I intend to elaborate upon in the remainder of my testimony, is based on the following reasoning: that such inclusion is unnecessary on the basis that effective cost containment mechanisms presently exist in prepaid dental programs; that dental costs are not a significant or uncontrolled factor in health care expenditures; that dental prepayment is so vastly dissimilar from hospital and medical/surgical benefit programs in size, structure and operation that it must be considered unique.

Moreover, it is the contention of the Delta Dental Plans Association that the inclusion of dental benefit programs in enacted legislation would, in fact, have a reverse or opposite effect of the intended legislation, resulting in the following: a total undermining of the present dental delivery and financing system as a result of adverse selection in groups seeking dental benefit programs; a concomitant escalation of costs that would make purchase of dental benefit programs prohibitive; a system that would discourage patients from seeking preventive services, which in turn would lead to greater expenditures for more extensive treatment at a later date. In short, present "pro-competition" proposals would not only permit, but actually encourage, employee selection of inadequate levels, or total exclusion, of protection against dental care expenditures.

DENTAL BENEFIT PROGRAMS ARE DIFFERENT FROM OTHER HEALTH COVERAGES

The typical dental benefit program differs from the hospital/medical program model in that the dental program is structured to provide greater benefits for diagnostic and preventive services with lesser benefits for restorative and replacement services.

This approach creates financial incentives for program subscribers to seek preventive dental services on a regular basis and to establish sound home care habits. The level of coverage for restorative services assures a sharing by the subscriber of the cost of those services, thereby encouraging the active participation and concern of the consumer.

Because susceptibility to dental disease is nearly universal, the need for preventive services to control such disease is highly predictable. Dental benefit programs, therefore, are not so much "insurance" as they are a means of prepaying the cost for prevention and treatment. To a large extent, the seeking of dental care at any given time is a discretionary act by an individual. For a dental care program to be financially feasible and stable in its operation, however, it is necessary that enrollment of the subscriber population be accomplished through a single decision by a group purchaser, rather than through decisions by each member of the employee group.

As a practical matter, most prepayment organizations and insurance carriers will not enroll groups of 25 or less employees. Dental benefit programs are sold only on a group basis, not to individuals.

The key to a dental program's stability is that individuals in the group represent the entire spectrum of dental care needs including both those who require an extensive amount of dental treatment involving many dental visits and a relatively high overall cost as well as those individuals who may rarely require dental care services. A dental benefit program involves establishing a per-person cost for the entire group, regardless of the level of need, in order to cover the cost of the services required by the group. To permit individuals within a group to withdraw on the basis of their own limited need or desire, immediately has the effect of substantially increasing the cost of the program for the individuals electing to retain dental coverage. This effect occurs when individuals, knowing they may not immediately require dental care, or who have recently had extensive dental treatment, or who wish to postpone necessary health care, withdraw from the population base. This creates an "adverse selection" situation which in turn causes the costs of the dental benefit program to escalate substantially.

The features of pro-competition proposals which allow employees to have the option of tax-free cash payments in lieu of dental benefits would result in the same effect. Delta Plans, for example, have considerable experience with the difficulties inherent in voluntary enrollment dental programs. Delta's experience with these programs has shown that the cost for voluntary enrollment is significantly higher than standard mandatory enrollment programs.

DENTAL PROGRAMS ARE COST-EFFECTIVE

In the last 15 years, coverage under dental benefit programs has increased more than twenty-fold to the point that today 75 million Americans - - one out of every three citizens - - have some form of dental benefits. This has expanded the availability of comprehensive dental care and improved the dental health of these subscribers. During this decade it is anticipated that the number of Americans with dental benefits should reach the 90 million mark. This growth has been achieved without the extreme inflation in dental treatment fees that has afflicted other health care disciplines. While the number of Americans covered under dental benefits increased dramatically over the past decade from 12 million people, or 6 percent of the population, to 74 million, or 33 percent at the end of 1979, the rate of increase in the cost of dental services actually was lower during this same period than the rate of increase for all services in 1970-79. (See Exhibits I and II).

A major goal of proposed "pro-competition" legislation is already being achieved in the dental prepayment industry: that of increasing consumer sensitivity to health care costs. This is being accomplished through the use in nearly all dental benefit programs of deductibles, copayments and maximums - - cost-sharing mechanisms which remind the consumer that health care is not free, that alternatives are possible, and that economic considerations should enter into decisions regarding health care and its use.

It is Delta's belief that health care financing systems should possess three characteristics:

- Encourage the consumer to use appropriate preventive services;
- Provide the consumer with adequate protection against major expenses;
- Encourage and promote cost-effective awareness to the consumer of the importance of regular preventive care on a routine basis.

These mechanisms, or characteristics, exist today in the prepaid dental system where they have the effect not only of containing costs, but also of improving the quality of care received in that they encourage the redirection of choices toward effective and efficient services.

Another goal of the proposed "pro-competition" bills is to contain and reduce expenditures for health care. It is interesting, therefore, to note that, historically, increases in the cost of dental care have been significantly less than for health care costs in general and have been in line with increases in consumer prices experienced over the past decade.

Another important consideration is that the long-term effect of prepaid dental care programs has been to reduce the need for dental services. This can be illustrated by adjusting the average patient-cost to reflect a fixed (non-inflated) dollar. These studies show a decline in the need for dental services. Experience studies for the years 1973 to 1980 reveal that although the actual cost per patient increased 36 percent over this period, the costs adjusted for inflation declined 15.4 percent. Prepaid dental programs encourage patients to seek care regularly, thus preventing the need for extensive treatment which would have been required at a later date solely through neglect and deferment of treatment. (See Exhibit III.)

With respect to present dental benefit programs, most major prepayment organizations design and structure benefits to assure that diagnostic and preventive services are covered at a higher level than restorative or replacement services. Additionally, most programs provide higher levels of benefits for basic restorative services, silver amalgam fillings, for example, than for major restorative services.

This method of "weighting" benefits produces two desirable effects: first, it rewards the patient who takes care of his oral health; not only does he or she require less-costly services, but the services received are fully or largely covered by the program. Secondly, it assures that all program subscribers maintain a financial interest in their dental health and the costs of restoring it when dental disease occurs. Subscribers are made aware, therefore, that if they fail to maintain their teeth properly, substantial treatment costs, in which they will share significantly, await them. Those subscribers who do require major restorative care are also reminded of the cost involved - they maintain the same consumer interest in the cost of care as the patient without benefits because, unlike many other forms of health insurance, dental programs were never intended or designed to cover the entire cost of care.

It is clear that the proposed pro-competition legislation reflects concerns with rising health care costs. These concerns are shared by the Delta Dental Plans Association. It is our belief, however, that the proposed measures should be directed specifically to hospital and medical/surgical programs as dental benefit programs are demonstrably different in design, intent and effect on the economy.

For example, the Committee's attention is called to recent American Dental Association data which cite that of the total $235.1 billion expended on health care for the 12 month period ending September 30, 1980, only $3.1 billion was paid through non-governmental dental prepayment and insurance programs. What is being contemplated in proposed legislation, therefore, would result in undermining a health care financing system that is already accomplishing the various bills' intent, and yet accounts for less than 2 percent of total health care expenditures. (See Exhibit IV).

SUMMARY

The prepaid dental care industry has and continues to support and promote the objectives to which "pro-competition" legislation is addressed. Dental prepayment programs have successfully contained dental care costs while increasing accessibility of the American public to that care. As a result, the quality of care delivered and the improvement of the oral health of the nation have been increased to new levels. A factor in this record of achievement has been the growth of employer-sponsored group dental benefit programs.

It is the position of the Delta Dental Plans Association that the exemption of dental benefit programs from any legislation similar to that proposed in the various pro-competition bills would not diminish in the least the capacity of such legislation to control health care costs, and would insure the continued positive effects of prepaid programs on the oral health of the nation.

The Delta Dental Plans Association believes that the inclusion of dental benefit programs in such proposed legislation is unnecessary for the following reasons: effective cost containment mechanisms are already an effective part of prepaid dental programs; dental care costs are not a significant or an uncontrolled factor in health care expenditures, and dental benefit programs are by nature and operation totally different from hospital and medical benefit programs.

Moreover, the Association strongly believes that the inclusion of dental benefits into legislation with the current provisions will have an opposite, and unwanted, effect of undermining a successful, growing and cost-efficient system through the creation of adverse selection forces in group dental prepayment, which will drive up the cost of dental benefit programs to those still seeking them.

The impact of this proposed legislation will be to increase, not decrease, the cost of dental care and will reduce the likelihood of a large segment of the population now receiving care to attain a maintenance level through access to preventive services. These effects are, in our view, inflationary and will achieve quite the opposite effect intended.

It is our sincere belief, therefore, that the best interest of the American public would be served by exempting dental benefit programs from the provisions of the proposed legislation.

Thank you.

APPENDIX

Percentage of Population Covered By Dental Prepayment Plans

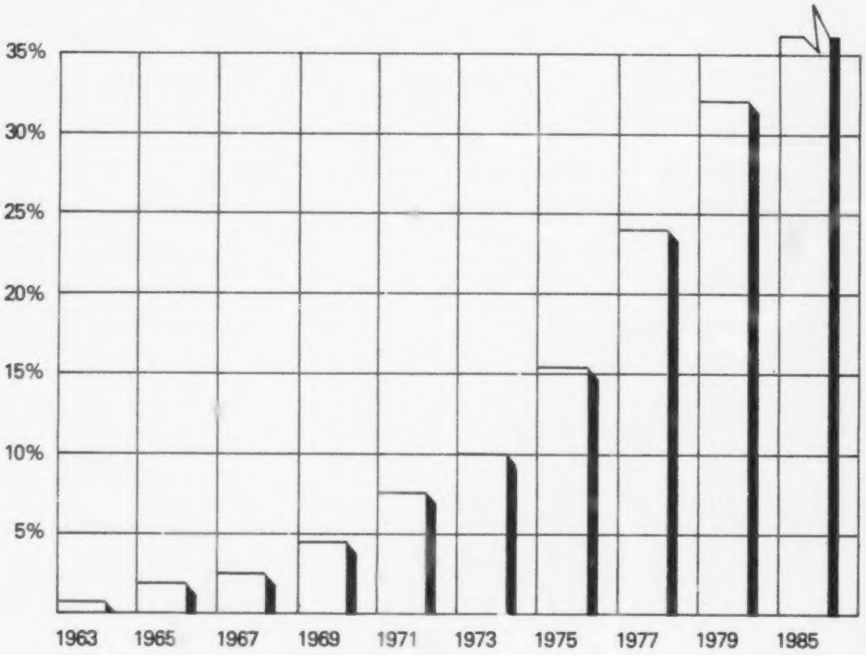

Exhibit I

Percent increase in CPI between
1967 - 1977

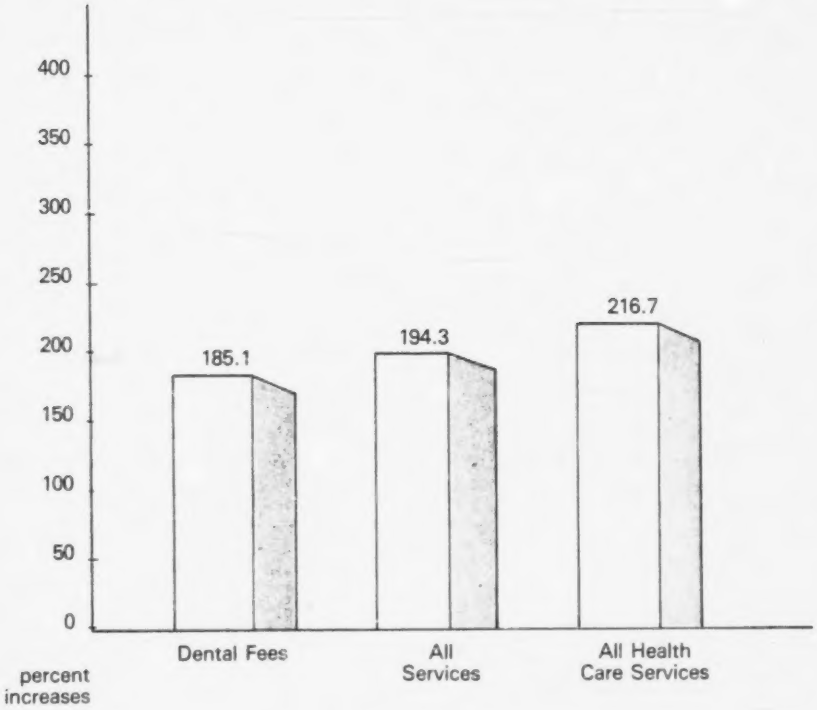

EXHIBIT II

Source: Data derived from Annual Report of the Council of Economic Advisors; Washington, D.C.: Executive Office of the President; 1978.

Cost per Patient

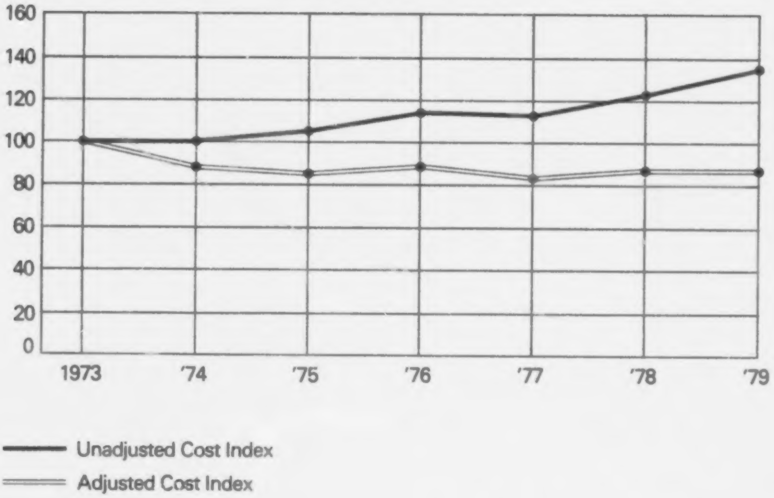

EXHIBIT III

12 Month Period Ending September 30, 1980

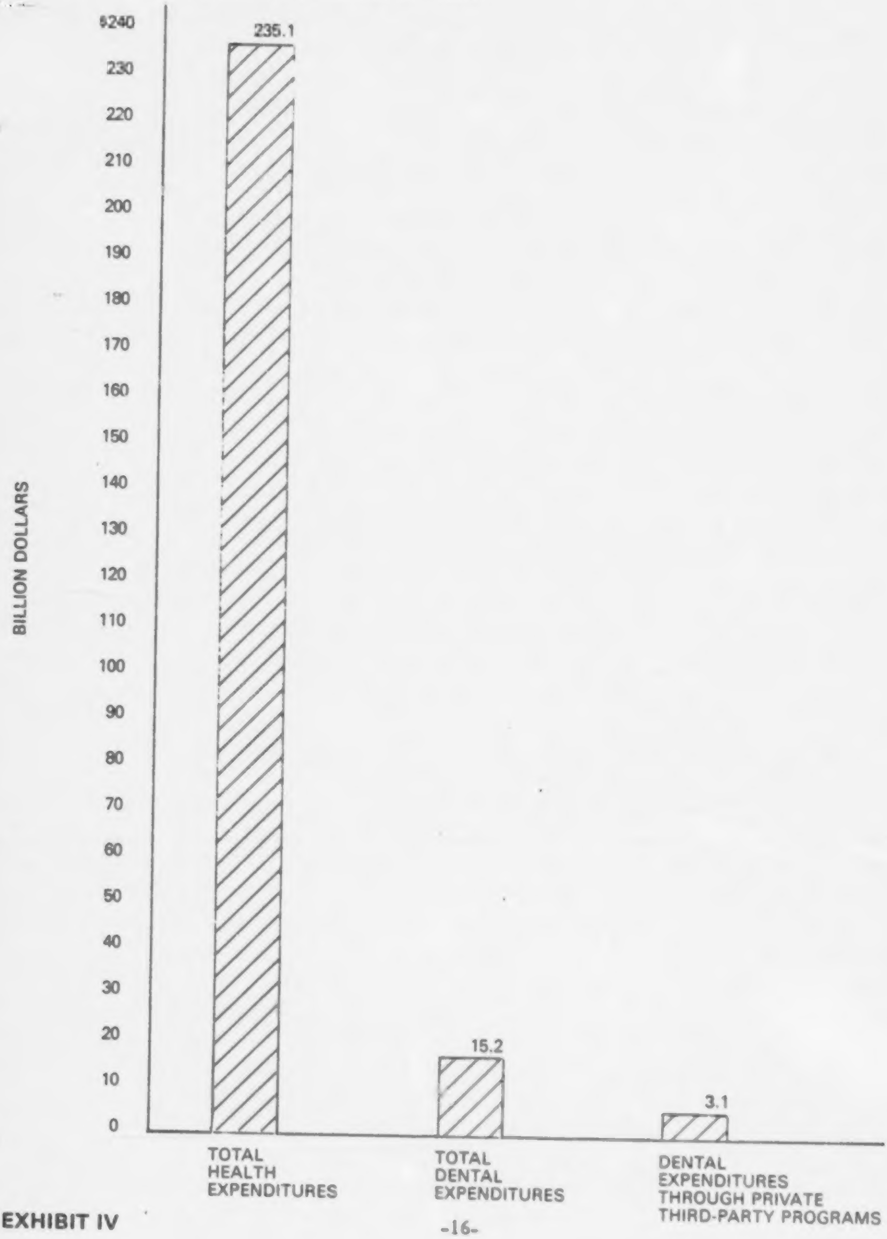

EXHIBIT IV

Chairman **Jacobs**. Thank you very much, Doctor. Mr. Gephardt.

Mr. **Gephardt**. Thank you, Mr. Chairman, and thank you all for your testimony. I have followed closely the work of your organizations in my area in St. Louis, and believe that dentists have led the way in both prepayment and in preventive care—and in education of consumers about the need for preventive maintenance of their teeth.

My question is, having paved the way in setting a model, I think, for the whole industry in prepayment and in the necessity and the efficacy of preventive care, I am wondering why you are troubled with the continued opportunity to compete. If 50 million Americans now have chosen dental benefits, I think you have clearly shown there is a market demand, and under most of the bills there is nothing I know of to preclude a qualified plan from offering dental benefits.

My question is, Why do you want to be excluded? Why do you want to be written out of the legislation rather than just being included as one of the services that can be offered?

Dr. **Olsen**. I will take a shot at that. I believe the electiveness, the predictability of dental disease places us at a severely greater risk in the adverse selection process. It isn't just a frustrating situation on adverse selection; in fact, it is a destructive situation. This has been proven by the fact, in dental benefit programs today, no one can sell it on an actuarially sound basis to a group of fewer than 25 people. And there is probably the likelihood you would lose money at that level. Therefore, the individual selection, with the preknowledge of dental conditions and its perceived discretionary nature have made it absolutely impossible to sell dental programs on an individual selection basis.

I wish this weren't true, but it is true in the experience we have had. Therefore, since we feel that we have succeeded in attaining the goals you are after, and the fact that the adverse selection problem could in effect destroy the dental prepayment financing system as it exists today, are adequate reasons for exempting these benefit plans from the legislation.

Dr. **Stephens**. We do have a slightly different interpretation of the same facts that Dr. Olsen is speaking of. What the Academy of General Dentistry is doing is viewing the realities of the situation should such legislation be passed. What we are saying is that to exclude us—we don't wish to be excluded—from the legislation is not what we feel would be in the best interests of dental health care, for the simple reason that once the rest of health care is mandatorily provided for under a monetary cap, we are not sure that employers will gratuitously then provide the nation with tax-free dental care. However, we do feel, as Dr. Olsen feels, that dentistry is a different kind of health care and has to be marketed in a different way. We suggest that it be put under a separate cap, so that it can compete fairly with medical health care.

Your statement, "I don't understand why you wish to be removed from the competition," speaks to part of the problem dentistry faces when competing with medicine, but not completely. The competitive sphere in which dentistry and medicine will be placed will be unfair to dentistry and will pose difficult choices for Americans. It is very difficult to choose between the cost of medical health care, which can be catastrophic to Americans, and the cost of dental care, which is not always as catastrophic. Furthermore, the risks of dental disease are not perceived to be as great as the risks of medical disease. Mr. Tucker may assist me in making that clear to you, that we don't wish to be excluded. The realities, should such legislation be passed, make necessary a separate monetary cap for dentistry.

Mr. GEPHARDT. I understand the cap, and there may be different caps in different bills, but one of the caps in 850, the cap in 850 is set by what people are choosing in a particular area. That is how we arrive at it, and I fail to understand how you are injured if what people actually choose—and you are telling me that 50 million people are choosing you now; if you have done that well in the marketplace, and I can understand why you have—why that would be altered by the imposition of competitive legislation.

Mr. TUCKER. Congressman, really, we would like to take the credit as dentists for achieving that rate, but we must share that credit with the collective bargaining process. If you exclude dentistry from a mandated separate cap, and leave it in its current status as a tax-exempt fringe benefit, and that tax-free fringe benefit were to be allowed to continue then competition might be valid.

It is our contention that, first of all, if dental benefits are included as an option within the legislation but not mandated, you are then putting on the employer and the employee the burden of selecting three different health plans.

It could be one at $60, one at $80, and one at $120. The employee would have the choice of taking whatever plan he wanted, and receiving the difference back in rebate in cash. The first initial choice that the employee would make would be between his perceived health care needs and his perceived economic needs, and dentistry would not fare well within that choice in today's economy, and it would be an unfair competition.

If, however, dentistry were mandatorily included in a separate cap, subject to the same conditions of choice as medical health insurance, then it would compete fairly within the system.

Second, we believe that down the road if this legislation were implemented, and if the maximum were $120 per month, if at some point collective bargaining would go toward additional medical insurance or other additional types of fringe benefits at a risk to dentistry, which is not a perceived need, we would thus begin to lose the very groups that Delta Dental is talking about. It is only through a separate mandated cap that those groups could be preserved.

Mr. GEPHARDT. Would you feel better about it if we allowed bargaining by groups as opposed to individuals, if we preserved that, and we didn't have a rebate, if they chose something less than the cap? Would that be a better approach?

Dr. OLSEN. That is the system as it now operates with bargaining groups, My basic problem—and here I am going to borrow from my physician friend who preceded me on the panel—"if it ain't broke, why fix it?

Mr. GEPHARDT. I guess we are in a position in my view where it is broke. It is broke because the budget is broke, and we are going to fix it, and we are either going to fix it through more regulation or we are going to fix it in putting caps on what can be spent, or we are going to fix it by trying to go to something called the competition, and there are lots of different definitions of what that is.

I don't think, as one of the speakers I think earlier said today, that the status quo is available. I think there are a lot of people that would like to keep the status quo, and I understand that. But if it is not available, I think the thing boils down to whether you want more regulation or whether you want to move to a competition kind of scheme, and I guess what I am trying to ferret out is which kind of scheme would be one that you could live with and that you would like.

Mr. **Tucker**. We would prefer to be included so that we can compete fairly. But in order to compete fairly, we must have the same ground rules as medical insurance, and that is minimal mandated services or a separate mandated dental cap. Without that, then dentistry becomes an option to be included in any one of the three or more plans, and as an option, then we compete unfairly with both the economy and are subject to the changes of this economy, and with catastrophic medical insurance.

We know that dental disease can be prevented, and it is through the dental prepayment plans that this has come about, so this is a cost savings to the country down the road as well as now. But to make us compete in a marketplace that is not fair would not achieve competitive aspects that we think you are going for.

Dr. **Griffiths**. I would like to add to that. The position of the American Dental Association is that a separate cap simply doesn't answer the problem that Dr. Olsen brought up of adverse selection. I think one of the things you have to recognize in dental insurance is that it has an automatic cap built into it in that there are limits to what an individual can collect under those per year, which automatically limits what the insurance company can pay. Anything above that, the person himself must pay.

If the limits are $750 a year and the bill is, say, $1,000, then he has to come up with that difference beyond what the limits are. This is an automatic cap as far as we are concerned in that insurance coverage. So that we don't need another cap on top of that one to help control the costs. And it has worked, because you look at the Consumer Price Index and you see the dental fees have stayed down, even though we are covering a lot more people under insurance coverages.

Dr. **Stephens**. We are not disagreeing with Dr. Griffiths' point that dental insurance has a built-in cap. We are saying, however, that unless dentistry receives a separate, mandated cap, Dr. Griffiths' point will be moot because there will not be funds available to purchase dental insurance if we are forced to unfairly compete with medical insurance and/or tax-free cash rebates.

Without legislating a mandated, separate cap, of course, to assume that these same kinds of programs are going to be gratuitously provided by an employer tax free is a little naive, so these fine points of regulation which have made the whole dental prepayment so successful will gradually be eroded. Employers will gradually not have the large groups through which these benefits become available, because they won't be providing large groups with tax-free dollars, and so these dental health care benefits become an option.

The realities of it are that if the legislation is enacted, we would like dentistry to be included, as a separate mandated cap, taking those things about dentistry that make it unique in the practice of health care, and making them work. A separate cap relieves that unfair competition that would exist if we are under the same cap with medicine, because over the period of time we feel that the dental benefits which have up until now been included under dental prepayment are going to be eroded. Prepaid dentistry, with all of the wonderful things that we have now provided, won't exist the minute employers can no longer provide it tax free.

Mr. GEPHARDT. I think I have exhausted my time. Thank you, Mr. Chairman.

Chairman JACOBS. Are there any further questions?

The committee expresses its gratitude to the panel for its participation.

The next panel consists of the National Association of Home Health Agencies, National Home Caring Council, the Home Health Services and Staffing Association, American Federation of Home Health Agencies, National Association of Temporary Services. Will the representatives of those organizations please come forward. Will you proceed in the order among yourselves, if that is all right.

STATEMENT OF JOHN B. SMITH, CHAIRMAN OF THE BOARD, HOME HEALTH SERVICES AND STAFFING ASSOCIATION

Mr. SMITH. Thank you, Mr. Chairman. Mr. Chairman and members of the committee, we will attempt to abbreviate our remarks. We have a full copy of our statement. My name is John B. Smith, chairman of the board of the Home Health Services and Staffing Association. My statement represents the views of our group, the National Association of Home Health Agencies, represented by its president, Mr. Liversidge, and of the National Home Caring Council. Ms. Layzer of the Council was detained in New York this morning and unable to be here.

The Council of Home Health Agencies of the National League for Nursing has reviewed and is also supportive of this statement, and plans to submit their own written statement.

These and other home health care organizations are dedicated to providing a broad range of quality health care services in the home at a less expensive cost to the patient. We are happy to be here to discuss the three procompetition health insurance proposals now before your committee.

Our primary question for all health insurance proposals has remained constant: Whether or not they encourage a continuum of health care nationwide with home health care services an integral part of that continuum.

Unfortunately, home care is now health care's stepchild, honored in words but assigned to the foot of the table in practice. Current medicare and medicaid expenditures for home health care are only about 2 percent and 1 percent of the respective program totals. Any health insurance legislation finally enacted must reverse the long-standing discrimination against noninstitutional services.

About 3.5 million noninstitutionalized older Americans are functionally dependent. These people are increasing by 100,000 each year. By the year 2030 an estimated 7 million persons will fall into this category. One third of these functionally dependent people are homebound and bedfast.

It is estimated that if current patterns are unchanged, the number of nursing home beds must increase by 50 percent in the next 20 years. Yet studies indicate that between 10 and 40 percent of those older persons currently residing in institutions could be transferred from them if appropriate supportive services were available in the community.

Such findings—coupled with research documenting that home-based care can be less costly and disruptive than institutional care—provide us with solid ground on which to challenge eligibility policies which foster unnecessary institutional placements. Whether or not present nursing home residents are moved back to the community, ways must be found to change the utilization patterns and prevent such inappropriate placements from continuing.

One projection of need for home care might be extrapolated from the experience of several European countries, where home help services—as they are called—are considered important enough to be given strong government support. While the United States reports a ratio of 1 home health aide for every 2,000 persons, in some of the Scandinavian countries the ratio of home health workers to individuals varies from 101 persons to 151 individuals.

Not only has the need for supportive, in-home services been persuasively documented, but its cost-effectiveness compared to institutional care has also gained increasing national attention. Coming on the heels of studies revealing significant dollar savings through the use of home-based rather than institutional services, the General Accounting Office has declared that,

> Until older people become greatly or extremely impaired, the cost for home health services including the large portion provided by families and friends, is less than the cost of putting those people in institutions.

Obviously, Mr. Chairman, we are pleased that home health coverage is required of qualified plans under all three proposals before your committee. However, these requirements appear to adopt the approach of the medicare program to home health services.

For example, Mr. Gephardt's bill requires home health services as a basic service only for the elderly and disabled, whereas the Durenberger and Hatch bills require home health services for all participants in a basic plan. We would commend you to the approach of the last two bills.

There are several other problems here which should be addressed as you work on legislation.

First, incentives for the use of noninstitutional rather than institutional services should be provided. Congress enacted legislation last December as part of the budget reconciliation bill, which took steps in this direction. But in medicaid particularly the institutional bias remains. This institutional bias is compounded by the fact that public expenditures for social services and community housing arrangements, which can often make the difference in helping a person to live independently, have been limited to date. The result is that except perhaps in New York few funds have been spent on home health care under the medicaid program.

Second, homemaker-home health aide services should be authorized under the equivalents of both the medicare and medicaid programs.

The limited availability of social service back-up has been a major barrier to the increased use of home health care services in this Nation. When an older person is in a nursing home or other institution, the provision of such environmental tasks as meal preparation, light houskeeping, laundry, and the like is taken for granted. Such environmental services must be available in a comprehensive fashion with personal care services in order for that person to maintain him or herself in the community.

Unfortunately, the current situation in this country is far from comprehensive. In some cases, individuals are able to receive environmentally-focused homemaker services under title XX of the Social Security Act or title III of the Older Americans Act. However, such services are limited because Federal grants are limited. Furthermore, the fragmentation and confusion caused by having two separate workers in one home—the home health aide and homemaker—are costly and counterproductive.

We urge that comprehensive homemaker-home health aide services be authorized under title XVIII—and by proxy, title XIX—to insure that older persons receive the environmental assistance they require to maintain themselves in a noninstitutional setting.

A final problem is reimbursement methodology. H.R. 850 appears to make the best effort to break with the present cost-based, retrospective system that is inefficient to administer and which does little to constrain costs.

Current methods of provider reimbursement under titles XVIII and XIX offer little incentive for service efficiency. Generally, home health care providers are reimbursed on the basis of reasonable costs, as determined retrospectively by the fiscal intermediary. This approach has spawned costly retroactive denials, which are not uniformly applied from one intermediary to another, as well as delayed payment in some instances which create serious cash flow problems for providers.

We feel that new approaches to provider reimbursement should be explored in an attempt to stimulate more efficient delivery of home health care services, and I believe Mr. Liversidge has some remarks on that subject. Consequently, we urge you and your committee to examine this question closely and to move toward more efficient forms of reimbursement for home health care.

Fundamentally, Mr. Chairman, we are concerned about one thing, that home health care take its proper place as a cost-efficient and humane part of the continuum of health care services. We believe that working with the bills before you will provide an opportunity to attain this goal. We pledge to work with you and your committee to make the most of it.

[The prepared statement follows:]

Statement of John B. Smith, Chairman of the Board, Home Health Services and Staffing Association

Mr. Chairman and members of the Committee, my name is John B. Smith, Chairman of the Board of the Home Health Services and Staffing Association. My statement represents the views of the National Association of Home Health Agencies, the National Home Caring Council, and the Home Health Services and Staffing Association. The Council of Home Health Agencies of the National League for Nursing has reviewed and is supportive of this statement and plans to submit written testimony. These and other home health care organizations are dedicated to providing a broad range of quality health care services in the home at a less expensive cost to the patient.

We are happy to be here to discuss the three "procompetition" health insurance proposals that are now before your Committee. Our primary question for all health insurance proposals has remained constant: whether or not they encourage a continuum of health care nationwide, with home health care services an integral part of that continuum. Unfortunately, home care is now health care's stepchild, honored in words but assigned to the foot of the table in practice. Current Medicare and Medicaid expenditures for home health care are only about 2 percent and 1 percent of the respective program totals. Any health insurance legislation finally enacted must reverse the long-standing discrimination against non-institutional services.

BACKGROUND: THE NEED FOR INCREASED HOME HEALTH CARE SERVICES

About 3.5 million noninstitutionalized Older Americans are "functionally dependent". These people are increasing by 100,000 each year. By the year 2030 an estimated 7 million persons will fall into this category. One third of these functionally dependent people are homebound and bedfast.

It is estimated that if current patterns are unchanged, the number of nursing home beds must increase by 50 percent in the next 20 years. Yet studies indicate that between ten and forty percent of those older persons currently residing in nursing homes could be transferred from them if appropriate supportive services were available in the community. Such findings—coupled with research documenting that home-based care can be less costly and disruptive than institutional care—provide us with solid ground on which to challenge eligibility policies which foster unnecessary nursing home placements. Whether or not present nursing home residents are moved back to the community, ways must be found to change the utilization patterns and prevent such inappropriate placements from continuing.[1]

One projection of need for home care might be extrapolated from the experience of several European countries, where "home help" services (as they are called) are considered important enough to be given strong government support. While the United States reports a ratio of one aide for every 2,000 persons, Sweden estimates one home help worker for every 101 persons; Norway, one for every 119 persons; and the Netherlands, one for every 151 persons. Finland credits its solid network of home help services with the substantial decline in its infant mortality rate in recent years.

Not only has the need for supportive, in-home services been persuasively documented, but its cost-effectiveness compared to institutional care has also gained increasing national attention. Coming on the heels of studies revealing significant dollar savings through the use of home-based rather than institutional services, the General Accounting Office has declared that, "until older people become greatly or extremely impaired, the cost for home health services including the large portion provided by families and friends, is less than the cost of putting those people in institutions." [2]

INCLUSION OF HOME HEALTH CARE IN PROCOMPETITION, HEALTH INSURANCE PROPOSALS

Obviously, Mr. Chairman, we are pleased that home health coverage is required of qualified plans under all three proposals before your Committee. However, these requirements appear to adopt the approach of the Medicare program to home health services. There are several problems here which should be addressed as you work on legislation.

First, incentives for the use of non-institutional rather than institutional services should be provided.

Congress enacted legislation last December which took steps in this direction. But in Medicaid particularly the institutional bias remains.

As this Committee is no doubt aware, Medicaid eligibility criteria in most states provide powerful incentives for institutional placement. Even those states which do not require pauperism prior to Medicaid eligibility require evidence of such outstanding medical expense that, in general, individual recipients do not have the means to maintain themselves independently in the community. This "institutional bias" is compounded by the fact that public expenditure for social services and community housing arrangements—which can often make the difference in helping a person to live independently—has been limited to date. The result is that, except in New York, few funds have been spent on home health care under Medicaid.

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[1] Davis and Gibbs. "An Areawide Examination of Nursing Home Use, Misuse, and Non-use." American Journal of Public Health, 61: 6, pp. 1146–55.

[2] General Accounting Office, "Home Health—The need for a National Policy to Better Provide for the Elderly," December 30, 1977.

Second, homemaker-home health aide services should be authorized under the equivalents of both the Medicare and Medicaid programs.

The limited availability of social service back-up has been a major barrier to the increased use of home health care services in this nation. When an older person is in a nursing home or other institution, the provision of such "environmental" tasks as meal preparation, light housekeeping, laundry, and the like is taken for granted. Such environmental services must be available in a comprehensive fashion with personal care services in order for that person to maintain him or herself in the community.

Unfortunately, the current situation in this country is far from comprehensive. In some cases, individuals are able to receive environmentally-focused "homemaker" services under Title XX of the Social Security Act or Title III of the Older Americans Act. However, such services are limited because federal grants are limited. Furthermore, the fragmentation and confusion caused by having two separate workers in one home—the home health aide and homemaker—are costly and counterproductive. We urge that comprehensive "homemaker-home health aide" services be authorized under Title XVIII (and, by proxy, Title XIX) to insure that older persons receive the environmental assistance they require to maintain themselves in a noninstitutional setting.

A final problem is reimbursement methodology.

H.R. 850 appears to make the best effort to break with the present cost-based, retrospective system that is inefficient to administer and which does little to constrain costs.

Current methods of provider reimbursement under Titles XVIII and XIX offer little incentive for service efficiency. Generally, home health care providers are reimbursed on the basis of reasonable costs, as determined retrospectively by the fiscal intermediary. This approach has spawned costly retroactive denials, which are not uniformly applied from one intermediary to another, as well as delayed payment in some instances which create serious cash flow problems.

We feel that new approaches to provider reimbursement should be explored in an attempt to stimulate more efficient delivery of home health care services. Consequently, we urge you and your Committee to examine this question closely and to move toward more efficient forms of reimbursement for home health care.

CONCLUSION

Fundamentally, Mr. Chairman, we are concerned about one thing: that home health care take its proper place as a cost-efficient and humane part of the continuum of health care services. We believe that working with the bills before you will provide an opportunity to attain this goal. We pledge to work with you and your Committee and make the most of it.

Chairman JACOBS. Thank you.

The next witness, please.

STATEMENT OF ROBERT P. LIVERSIDGE, JR., PRESIDENT, NATIONAL ASSOCIATION OF HOME HEALTH AGENCIES

Mr. LIVERSIDGE. Mr. Chairman, my name is Robert Liversidge, executive director of the Visiting Nurse Service in Toledo, Ohio, and president of the National Association of Home Health Agencies. The testimony which Mr. Smith presented does indeed represent our point of view. I would like to add by way of emphasis, however, the fact that the question of prospective reimbursement, we feel, is a serious one. We feel it is something which should be considered at least on a demonstration basis. The use of a cost-based retroactive reimbursement system is not effective. Speaking as an agency director, it is a very difficult system to work under, and causes untold problems in our agency. I think I can speak for other agency directors as well.

I also would mention that in the State of Ohio at the present time we have seven intermediaries, all of those approach claims and bill processing somewhat differently, and that, again, underscores the problem of the retroactive reimbursement system.

Mr. Smith mentioned the institutional bias. I would just like to add another situation in our State. At the present time, nursing homes in the State of Ohio are finding that they are getting regular increases in their level of reimbursement under medicaid. However, as far as home health is concerned, we have not received an increase in our reimbursement level since 1974, and I would ask you to look at what inflation has done to all of our agencies since that time. Of the 116 agencies in Ohio, every single one has costs above that reimbursement level. So, obviously, there is a disproportionate reimbursement there, and I think it is a serious problem.

Thank you.

Chairman JACOBS. Thank you for your testimony.

STATEMENT OF RONALD B. RECK, PRESIDENT, AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC., AND ADMINISTRATOR OF HOME HEALTH SERVICES OF ALLEGHENY COUNTY, PA.

Mr. RECK. Mr. Chairman, distinguished members of the committee, my name is Ronald Reck, administrator of the Home Health Services of Allegheny County, located in Pittsburgh, Pa. I am a representative of a small business home health agency, also president of the American Federation of Home Health Agencies. We are very pleased to have this opportunity to present our testimony on competition in the health care industry.

A little background for your information. The American Federation of Home Health Agencies is a national trade association representing small business, nonprofit, proprietary home health agencies across the United States. The federation was created in September of 1980 for the purpose of presenting a carefully reasoned picture of the private sector of the home health industry, to the Congress and to the Health Care Financing Administration. It was our belief that constructive input on behalf of the small business segment of the home health industry had been noticeably lacking in the past, and therefore we were created.

For the most part, the federation supports greater competition in the health care industry, as a means of providing more economical and higher quality health care to the elderly and disabled. While the federation actively supports competition, we do have reservations about some of the concepts and proposals we have been offered. In addition, we have serious reservations with some of the activities of the Health Care Financing Administration as they administer the present health care program.

Some of the present regulations and policies encourage waste, create inequities and are themselves anticompetitive. An example of this is the dual cost capping of home health providers. As you are aware or might not be aware, several types of entities provide medical care in the home. These include provider based hospitalization, freestanding private nonprofit, proprietary agencies, visiting nurse associations, local government.

Under HCF's present regulations, as implemented in July of 1980, the hospital-based home health agencies are reimbursed up to 47 percent more for the same services that the freestanding agencies are providing. While the American Federation understands that the justification for the higher reimbursement rates for hospital-based home health agencies is based on the allocation of higher overhead expenses for the hospitals, we do not find such logic persuasive. We believe that provider based agencies will take advantage of higher reimbursement rates when it is possible, including subcontracting outside the institution for such services. In such instances there will be no incentive to contain the cost at the same level of those with the freestanding agency.

We believe all home health agencies should be reimbursed at the same rate, regardless of auspice. The American Federation of Home Health Agencies believes that the present cost reimbursement methodology is a very poor system which easily lends itself to inefficiency and abuse. One method of changing this system is the creation of a voucher system as has been proposed in H.R. 850. Another alternative to the present method would be a reimbursement system on a prospective basis with profit incentives designed specifically for home health agencies. Such a system would reward business efficiencies, maintain and enhance quality in the system, eliminate retroactive denials, eliminate the Provider Reimbursement Review Board for home health agencies, eliminate some of the bureaucracy from HCFA and the fiscal intermediary and reduce the overall cost of the program.

The National Health Care Reform Act of 1981 would attempt to deregulate the home health care industry and permit competition to contain health care costs. The bill is designed to introduce financial incentives for health care providers to contain costs while improving quality and remove the method of payment, which now makes meaningful cost containment impossible.

The federation heartily supports the elimination of cost-based reimbursement. As most of you are aware, the cost of providing the service in a home is significantly less than providing the same service in a hospital setting. The cost of providing skilled intermittent nurse visiting services and the necessary equipment in the home is under $20 a day. The cost savings are obvious when it is compared to daily hospital costs.

While the freestanding home health agencies offers quality services at a competitive price, we are not sure the approach taken in H.R. 850 would promote true competition between all segments of the health care industry. We are concerned about an approach which would allow large competitors, in our case the well-financed hospitals, to eliminate the small business home health agencies from competition. As we read H.R. 850, qualified health care plans would compete for the voucher and other private parties interested in health care coverage themselves and/or their employees.

Each qualified plan would be able to freeze out many home health agencies by setting up their own agency, thus eliminating competition among agencies and plan members' freedom of choice in selecting the appropriate agency for their health care. AFHHA believes each plan should work with all qualified home health agencies in a given geographical area.

Perhaps the key to the success of a voucher system would be the nature and quality of the effort to inform potential plan members of their available choices. Home health services are one of this country's best kept secrets. The more informed the purchaser of health services becomes, the greater the gravitation toward home health care.

We are not suggesting that this committee sponsor legislation giving medicare home health undue preferential treatment. What we are suggesting is that this committee recognize that the small business industry of home health, which operates almost exclusively on a cost-reimbursement basis, can only effectively compete in the hospital-controlled environment or health care market if it is afforded equal treatment in terms of appropriate coverage and payment.

The American Federation of Home Health Agencies, Inc., urges that freestanding home health agencies from all auspices receive the same consideration under present and future programs that is afforded the hospital industry.

Thank you for your consideration, and we welcome working with staff and committee on future legislature

[The prepared statement follows:]

STATEMENT OF RONALD B. RECK, PRESIDENT, AMERICAN FEDERATION OF HOME HEALTH AGENCIES, INC.

Mr. Chairman, distinguished members of the committee, my name is Ronald B. Reck, Administrator of Home Health Services of Allegheny County, Pittsburgh, Pennsylvania and President of the American Federation of Home Health Agencies (AFHHA). I am very pleased to have this opportunity to present our Association's views on H.R. 850, the "National Health Care Reform Act of 1981" and other means of bringing more competition to the health care industry.

AFHHA is a national trade association representing small business, non-profit and proprietary home health agencies across the United States. AFHHA was created in September 1980 for the purpose of presenting a carefully reasoned picture of the private sector of the home health industry to the Congress and to the Health Care Financing Administration (HCFA). It was our belief that constructive input on behalf of the small business segment of the industry had been noticeably lacking in the past. AFHHA took an active part in the debate last year and earlier this year regarding certain provisions of the Omnibus Reconciliation Bills, and it intends to take an active part in health care issues throughout this Congress.

AFHHA is pleased that Representative Gephart and others have recognized the need to reexamine the presence of the federal government in the delivery of health care in this country. For the most part, AFHHA supports greater competition in the health care industry as a means of providing more economical and higher quality health care to the elderly and the disabled. While AFHHA actively supports competition, we do have reservations about some of the concepts and proposals we have seen offered. In addition, we have serious reservations with some of the activities of HCFA as they administer the present health care program. Some of the present regulations and policies encourage waste, create inequities and are themselves anti-competitive. While we have been requested to submit our position on H.R. 850, which we will do, we would like to first address these problems that exist under the present medicare laws.

DUAL COST CAPS

As you are aware, several types of entities provide medical care in the home. These include hospitals; private, nonprofit and proprietary agencies; visiting nursing associations and local government home health agencies. Under HCFA's present regulation, as implemented on July 1, 1980, the hospital-based home health agency may be reimbursed up to 47% more for the same service provided by the freestanding home health agency.

The best way to demonstrate the two-tiered reimbursement approach is to compare the current cost caps for hospital-based agencies with freestanding agencies. The comparison between these two types of providers within a standard metropolitan statistical area (SMA) is set out below.

	Hospital-based SMSA	Free-standing SMSA
Skilled nursing	$62.35	$47.19
Physical therapy	56.03	46.31
Speech pathology	58.88	47.83
Occupational therapy	55.71	46.95
Medical social service	56.91	55.24
Home health aide	54.13	35.34

While AFHHA understands that the justification for the higher reimbursement rates for hospital-based home health agencies is based on the allocation of higher overhead expenses for hospitals, AFHHA does not find such logic persuasive.

We believe the provider based agency will take advantage of higher reimbursement rates when it is possible, including subcontracting outside the institution of such services. In such instances, there will be no incentive to contain cost at the same level of those at the free-standing agency.

Accounting ledgerdemain may be used to distort the actual cost of the hospital-based home health agency, it will provide misleading cost comparisons between overhead cost medicare reimbursement services. For example, if overhead cost can be diverted to a home health agency associated with the hospital, then the average in-patient cost will appear lower. A more accurate picture of overall medical expenditures would be realized if reimbursement rates were the same for both hospital-based agencies and free-standing agencies.

Attached as addenda to this testimony, are three items which will show, in more detail, the issues which we are addressing. First, there are copies of two Federal Register notices from the Health Care Financing Administration. Both notices deal with dual cost caps but with decidedly different results. In 1979, HFCA stated that the government should not support inefficiently in the hospital-based agency. In 1980, they completely reversed themselves and provided a higher reimbursement rate for hospitals.

Second, a letter from Mr. Robert O'Conner, former Director of HCFA's Bureau of Program Policy who unequivocally states, in response to complaints about the dual cost caps, that HCFA presumes, in their regulations, that the hospital-based agency is more efficient than the free-standing agency. We find such an admission to be astonishing, but true.

Third, a proposal AFHHA submitted to this Committee and the Senate Financing Committee for consideration earlier this year when the reconciliation measure was under consideration. At that time, we estimated that the elimination of dual cost caps could save the government as much as $36 million. HCFA has raised questions with this figure by stating that the savings would be "only" $6 million. While they have not produced any reliable data to refute our figures, we firmly believe that the $36 million savings is much closer to reality than HCFA's figure of $6 million. But AFHHA further asks, "What's wrong with saving $6 million?"

PROSPECTIVE REIMBURSEMENT

AFHHA believes that the present cost reimbursement methodology is a very poor system which easily lends itself to inefficiency and abuse. One method of changing this system is the creation of a voucher system as has been proposed in H.R. 850. Another alternative to the present method, would be a reimbursement system on a prospective basis with profit incentives designed specifically for home health agencies. Such a system would reward business efficiencies, maintain and enhance quality in the system, eliminate retroactive denials, eliminate the Provider Reimbursement Review Board for home health agencies, eliminate some of the bureaucracy from HCFA and the fiscal intermediary and reduce the overall cost of the program.

Many ways have been proposed for determining the method of making payment to an agency. Under AFHHA's proposal, a fixed payment per visit would be provided to each home health agency in a specific geographical area. This is in some ways similar to the voucher system. Each agency would be allowed to conduct their business up to this per-visit payment amount and the difference between their cost and the payment would be returned to them as a profit. An important function of this profit motive is to weed-out the inefficient agency.

Such a system would be more free-enterprise oriented because it would promote efficiency rather than encourage waste and allow profit based on efficient management.

If Congress wishes to go forward with a voucher type system and create qualified health care plans, then this system could be incoroprated into such a plan provided that the plan carriers would be required to have a home health benefit.

LOWER COST OR CHANGES

The Medicare home health agency operates in a regulatory system which places burdens upon its effectiveness as a competitive provider. The traditional forms of health care covered under the Medicare program (in-patient hospital care and skilled nursing facility services) are also reimbursed by private insurance. Home health care is unique, in that payment is made for skilled intermittent visiting services; whereas, private insurance policies only cover private duty nursing, eight hour nursing shifts, during a recuperative period. Private duty nursing is not used to affect an earlier hospital discharge, a basic goal of Medicare's home health benefit.

In most instances, the private duty nursing company operates as an unregulated employmet service. The patient and his family are the nurse's employer. They must accept total responsibility for the quality of the services rendered, the maintenance of proper records and the billing to the private insuror. As an employment service, the private duty company avoids the administrative cost of employment taxes such as FICA, Workman's Compensation, FUTA, and state unemployment insurance; various types of business insurance such as medical malpractice and general liability; and other costs common to Medicare home health agencies in maintaining elaborate medical and administrative records.

Today, a major barrier to home health agency entry into the private pay market is Medicare's requirement that providers must bill the same charge to Medicare and any other payor for "the same services."

Under Medicare Regulation 42 CFR 405.455, the provider is limited to the lower of its cost or customary billing charges for the same service: If a provider's reasonable cost for Medicare skilled nursing visit is $30.00 and its customary billing charge for one hour of private duty nursing is $15.00, it is likely that the medicare intermediary would reduce the medicare reimbursement to $15.00 per visit. The adjustment would be based upon the conclusion that the agency's private duty nursing hour at $15.00 is the same service as its Medicare skilled nursing visit.

Home health agencies cannot provide private duty nursing services to private insurance carriers because to do so would subject their Medicare reimbursement to the lower charge, even though the services are substantially different.

While this regulation is a barrier which impedes free-enterprise from selling services to and receiving payment from private insurance, other medicare regulations grant public health department agencies a competitive advantage by allowing them to render home health services "free of charge or at a nominal charge" without being subject to the lower of cost or charge criteria.

Thus, the free-enterprise, small business Home Health Agency may neither charge the non-Medicare patient less than its customary charge to the program, nor enter the private duty nursing market which is available under third party insurance. If it did so, its total Medicare reimbursement would be computed based on this lower charge. The generally accepted business principle that an organization may set its prices based on the marketplace does not apply in the Medicare home health care industry. This and other restrictions on home health agencies, such as requirements that patients be homebound, and not custodial, make it difficult, if not impossible for a home health agency to be less than 80 percent to 90 percent Medicare.

H.R. 850, THE NATIONAL HEALTH CARE REFORM ACT OF 1981

The National Health Care Reform Act would attempt to deregulate the health care industry and permit competition to contain health care cost. The bill is designed to introduce financial incentives for health care providers to contain cost while improving quality, and remove the method of payment which now makes meaningful cost containment impossible.

It is also intended to give the American People the ability to determine what health care they want, how much they wish to pay for it; and to enable those Americans who now have little or no insurance to buy basic health care protection.

It would phase-out cost based reimbursement for hospitals and home health agencies.

AFHHA heartily supports the elimination of cost based reimbursement. As most of you are aware, the cost of providing health care in the home is significantly less than providing the same care in a hospital setting. The cost of providing intermittent visiting nursing services and the necessary equipment in the home is under $20 per day. The cost savings are obvious when compared to daily hospital costs.

We have heard much about the voucher approach to health care on a national basis but have not been any evidence that such a system actually contains costs. What we see in H.R. 850 is a turning over of a most, if not all, of the Medicare program to the private segment of our economy.

While AFHHA supports abolition of the cost reimbursement system we believe the voucher system should be very carefully and thoroughly examined before passage. It is to say the least, a very significant change in the federal government's presence in health care.

TRUE COMPETITION?

While the free-standing home health agency offers quality services at a competitive price, we are not sure the approach taken in H.R. 850 would promote true competition between all segments of the health care industry. We are concerned about an approach which would allow large competitors, in our case the well financed hospital, to eliminate the small business home health agency from competition.

As we read H.R. 850, qualified health care plans would compete for the voucher and other private parties interested in health care coverage for themselves and/or their employees. Each qualified plan would be able to freeze out many home health agencies by setting up their own agency thus eliminating competition among agencies and plan member's freedom of choice in selecting the appropriate agency for their health care. AFHHA believes each plan should work with all qualified home health agencies in a given geographical area.

INFORMED CHOICE

Perhaps the key to the success of a voucher system would be the nature and quality of the effort to inform potential plan members of their available choices. Home health services are one of this country's best kept secrets. The more informed the purchaser of health services becomes, the greater the gravitation toward home health care. As noted earlier, most private insurance plans do not cover health services in the home other than private duty nursing. This is partly tradition and partly a lack of information as to the costs and availability of health care in the home.

PROBLEM AREAS

AFHHA has specific problems with Section 202(b)(1)(B) which requires a qualified plan to include all levels of institutional health services while setting minimum limits for home health services to the aged and disabled for at least 100 days for any distinct spell of illness. We are concerned that this approach once again fails to recognize the value of home health services as a substitute for hospitalization. We, therefore, recommend home health care in that section.

In addition, Section 202(b)(2)(A)(ii) limits the basic health care services to "service[s] appropriate for the diagnosis or treatment of, or rehabilitation following, injury, illness, or disease." This provision appears to preclude long-term chronic illness from coverage as well as the maintenance of a person who has become ill but who may not have rehabilitative potential.

CONCLUSION

Today, Medicare patients receive hospital and nursing home services from many of the same providers that existed prior to the Medicare laws. The hospital and nursing home industry have made income after expenses which have promoted their financial stability. Based upon this income, these organizations are more capable of competing. They can generate funds for capital expansion and initial operating revenue through both short- and long-term borrowing. They can routinely issue bonds.

The evolution of the Home Health Industry has been a different story. Profit-making Private Duty Agencies have rarely participated in the Medicare program. The average home health agency is a very small organization. Its revenue, after expenses, if any, are nominal. Industry wide, 80 percent or more of the gross income is reimbursed on cost only basis (Medicare, Medicaid, United Way, Blue Cross and various government programs).

Without excess revenues, the home health agency has great difficulty financing expansion. It requires approximately $40,000 working capital to run an agency with a $500,000 annual budget. An Administrator whose annual compensation will rarely exceed $25,000 does not have substantial credit beyond that used in financing day-to-day operations.

AFHHA is not suggesting that this Committee sponsor legislation giving Medicare home health agencies undue preferential treatment. However, we do suggest that this Committee recognize that this small business industry, which operates almost exclusively on a cost reimbursement basis, can only effectively compete in the hospital controlled health care market if it is afforded equal treatment in terms or appropriate coverage and payment.

AFHHA urges that free-standing home health agencies from all auspicies receive the same consideration under present and future programs that is afforded the hospital industry. Elimination of dual cost caps, bonding and escrow requirements, and the lower of cost or charges and eventually the substitution of a prospective reimbursement system for the present system would promote greater utilization of home health care by the private sector thus reducing costs to the government without lowering the quality of care provided.

Thank you for your consideration. We look forward to your questions.

Chairman Jacobs. Thank you.

Mr. Richner?

STATEMENT OF CEDRIC A. RICHNER, JR. (SENIOR VICE PRESIDENT AND GENERAL COUNSEL, KELLY SERVICES, INC.), AND CHAIRMAN, LEGISLATIVE AND LEGAL COMMITTEE, NATIONAL ASSOCIATION OF TEMPORARY SERVICES, ACCOMPANIED BY JOSEPH HEENEY, EXECUTIVE VICE PRESIDENT

Mr. Richner. Thank you. My name is Cedric Richner, vice president of Kelly Services, the Kelly Girl people. I am also chairman of the Legal and Legislative Committee of the National Association of Temporary Services. I have with me Mr. Joseph Heeney, executive vice president of that association. The association does support a procompetition approach to the health care delivery system, and does support health care coverage for all employees. We do, however, take a little bit of a different look at the bills before you than many of the witnesses that you have heard.

We look at these bills from the standpoint of employers who have an extremely high turnover rate in our particular industry. The temporary services industry supplies temporary help to a wide variety of customers, businesses, government, health care institutions, any organization that needs temporary help and assistance on an ongoing basis to handle their excess or special workloads.

Temporary help companies such as my company or manpower, as an example, employ thousands of people during the course of a year to work temporarily on the premises of our customers. We are the employer of these people, we pay their wages, withhold all taxes and all other mandated employer obligations, plus paying additional fringe benefits. The persons we employ come from diverse backgrounds, some are between permanent jobs, some are between semesters, some are people who wish to supplement their family income or their own income. Some, a great majority, are people who simply do not want to make the commitment to full-time employment.

The temporary service companies such as my company provide the opportunity for this short-term employment and do not require the long-term commitment of employers of permanent personnel.

Because of this short-term commitment, the turnover rate of employment in the temporary services industry approaches 1,000 percent per year, while the normal turnover rate in most industries of employers of permanent personnel is approximately 4 percent.

Viewed in terms of employee productivity, the employer of permanent personnel must employ slightly more than one person each year to obtain one person-year of productivity. The temporary service companies, on the other hand, must employ approximately 10 persons each year to obtain 1 person-year of productivity. Thus, any legislation that requires all employers to pay for employee benefits imposes greater burdens, greater cost per hour of productivity on temporary service companies than on employers of permanent personnel.

This is especially true if the cost is required for nonworking time, such as post-termination of employment benefits. If coverage is mandated for 60, 90 days or more of post-termination coverage, the coverage exceeds the average normal productive working time of a temporary employee.

For example, Senate bill 139, Senator Hatch's bill, attempts to reduce to a limited extent this disparate disproportionate burden by requiring an employee to work a minimum of 25 hours per week for 30 days in order to be eligible for health care coverage by an employer. This approach is intended to relieve employers of the burden of providing health care insurance coverage for employees who only have a short-term relationship with the employer.

In the conventional job market, a person who works for 30 days can be assumed to retain his employment for several years. This is not true in the temporary services industry. Thirty days' employment with the temporary help company in no way indicates that the person will have an ongoing employment relationship with the temporary service company. It is highly unusual with the turnover rate of 1,000 percent that an employee who works for a temporary service company for 30 days would work for even a year.

Although the bills being discussed today are voluntary in terms of employer coverage, the unique employer-employee relationship in the temporary service industry must be factored in this type of legislation, especially if the coverages will be made mandatory. We support this type of legislation, we want to avail ourselves as employers of it, but we do have this unique employer-employee situation that we present to you, and we support any effort that you make in factoring this type of relationship into your legislation.

Thank you very much.

Chairman JACOBS. Thank you, sir.

[The prepared statement follows:]

STATEMENT OF THE NATIONAL ASSOCIATION OF TEMPORARY SERVICES

I. SUMMARY

The temporary service industry is concerned that health insurance proposals now being considered by Congress and proposals to be introduced have the potential for a uniquely severe impact on temporary service companies. The temporary service industry employs people who desire short-term employment. It has an employee turnover rate of approximately 1,000 percent per annum. Because the industry's turnover rate is so high, the industry can be devastated by some, but not all, legislative proposals that would require employers to finance health insurance benefits for temporary employees.

II. STATEMENT

A. Structure of the industry

Mr. Chairman and members of the subcommittee, I speak today on behalf of the National Association of Temporary Services, an organization comprised of 350 temporary help companies with 3,000 offices throughout the United States, representing 85% of the total sales of the industry. Our members are engaged in the business of supplying temporary help to a wide variety of customers including businesses, institutions, public agencies and other organizations that require assistance in handling excess or special work loads. To perform these services each temporary help company assigns its own employees on a tempoary basis to fill the needs of its customers.

Kelly Services, Inc., Manpower, Inc., The Olsten Corporation, Norrell Services, Inc. and Staff Builders, Inc. are perhaps the best known employers in the industry. The temporary service industry exists because of two facts: (1) many people in this country are available for employment on a short-term basis, and (2) many businesses need readily available, short term assistance. Temporary service companies serve the needs of both groups. Temporary service companies are employers who pay the temporary employee's wages, withhold all appropriate taxes and contributions, pay the social security taxes and unemployment compensation, provide worker's compensation benefits, and assign the temporary employees to a customer who needs temporary help.

Because of the extraordinarily high rate of turnover experienced in the temporary service industry, any legislation which requires all employers to provide employee benefits places significantly greater burdens on temporary service companies than on other employers. The best available turnover data shows that employers of permanent personnel experience an annual turnover in their workforce of approximately four percent. Various internal studies in this industry shows that temporary service companies experience an annual turnover rate of approximately 1,000 percent.

Viewed in terms of employee productivity, the statistics demonstrate that employers of permanent personnel must employ slightly more than one person each year to obtain one person-year of productivity. A temporary service company, on the other hand, must employ approximately 10 persons each year to obtain one person-year of productivity. Accordingly, legislation that requires all employees to pay for employee benefits would impose greater costs per hour of productivity on temporary service companies than on permanent employers.

The disparate burden on temporary service companies would increase dramatically if they are also required to provide post-termination benefits for employees. Employers of permanent personnel would be required to provide post-termination benefits annually to approximately four percent of their workforce. In contrast, the internal surveys of temporary employees shows that temporary service companies would be required to provide post-termination benefits each year to virtually all of their workforce (approximately 99.9 percent).

Moreover, the magnitude of this disparate impact would be increased many fold because temporary service companies also must hire approximately 10 times as many employees as permanent employers in order to obtain a single person-year of work.

B. Awareness of extraordinary impact of employer-financed benefit plans on temporary service industry is required.

The Ninety-Seventh Congress is currently considering several different proposals to stimulate competition in the financing and delivery of health care. The three pieces of "pro-competition" legislation that have received the most attention to date are: H.R. 850, National Health Reform Act of 1981 (Rep. Gephardt); S. 433, Health Incentives Reform Act of 1981 (Sen. Durenberger); and S. 139, Comprehensive Health Care Reform Act (Senator Hatch). These bills suggest different approaches to administration, enrollment, benefits and financing of health insurance. Again, it is the area of employer-financing that is of most concern to the temporary service industry.

As currently drafted, these proposals do not require that employers provide insurance or contribute to their employees' purchase of insurance from qualified plans. Rather, these proposals continue favorable federal income tax treatment to those employer contributions that meet certain eligibility standards. This allows each employer to decide whether or not it is financially feasible to offer a health insurance plan. The National Association of Temporary Services endorses this concept.

Over the past several years, a number of national health insurance proposals have been considered which require that employers contribute a fixed percentage of the total premiums for basic or catastrophic health insurance for each employee. These contributions would begin as of the first day of employment and would continue, at a minimum, until the termination of the employment status. For the temporary service company the question then arise as to whether contributions toward an employee's health insurance would be required for non-working time. That is, would the temporary service employer be obligated to pay a monthly premium in advance for an employee who may well not work for the full month and, further, would the employer be required to continue these benefits after employment terminates.

There is a provision in S. 139 that would reduce to a limited extent the disproportionate burden that temporary service companies must shoulder—if that bill was enacted and coverage made mandatory—the provision requiring the employee to work a minimum of 25 hours per week for 30 days in order to be eligible for coverage. This provision, however, would not reduce the temporary service companies' insurance costs to a point that would allow these companies to employ (and insure) great numbers of people who desire to work only on a short-term basis.

The requirement that an employee work for 30 days before becoming eligible for insurance coverage evidently is intended to relieve employers of the burden of providing health insurance to employees who will have only a short-term relationship with an employer. In the conventional job market it may be true that if an employee remains on the job for 30 days, he or she is likely to work for the employer for several years. Thirty days of work by a temporary employee does not indicate that the employee is prepared to have an ongoing relationship with a temporary service company.

Temporary employees generally turn to a temporary service company for the reason that the company provides an opportunity for short-term employment whereas other employers require a long-term commitment. In the main, temporary employees are people who are between semesters, or betwen permanent jobs, people who will soon move from the area, housewives who wish to supplement the family income because of a special need, permanent employees who need extra income, and persons who simply do not want to work on a full-time basis. If temporary employees were generally willing to commit themselves to ongoing service with a temporary service company, or if temporary service companies required such a commitment, the industry's turnover rate would be dramatically reduced.

In sum, it is highly unusual for any temporary employee—even one who works for 30 days—to continue to work for a temporary service company for a year or more. Unless the ramifications of the unique employer-employee relationship existing in the temporary service industry are factored into the proposed "pro-competition" bills, temporary service companies may be required to pay premiums for many employees in order to receive a single person-year of work and would be required annually to provide post-termination benefits for virtually every one of its employees who qualify for health insurance.

III. CONCLUSION

Temporary service companies are pleased to employ persons who desire only short-term employment. This arrangement is beneficial to the company, to the temporary employee, to customers who use the temporary service, and beneficial for the economy which generally makes little use of the labor and skills of persons who are unwilling or unable to commit themselves to permanent employment. These benefits may be significantly reduced or snuffed out if Congress, in enacting health insurance legislation, fails to take account of the fact that temporry service companies neither demand nor receive long-term commitments from employees, that they experience inordinately high turnover because they serve customers and employees who need each other only temporarily, and that employer-financed health insurance and post-termination coverage will cost temporary service employers many times more, per hour of productivity, than they will cost employers of permanent personnel.

In our view, a balance needs to be struck between the undeniable social value of providing health care benefits to all persons and the special economic burdens that an employer-financed health program places on the temporary service industry because it employs persons who do not intend to establish a continuous employment relationship. The balance is fairly struck if Congress provides a funding mechanism that takes into account the unique employer-employee relationship existing in the temporary service industry.

Thank you for the opportunity to present our views.

Mr. Duncan.

Mr. DUNCAN. I have no questions. I would like to thank the panel.

Chairman JACOBS. Mr. Gephardt.

Mr. GEPHARDT. I have no questions, Mr. Chairman. I understand the testimony and appreciate it and appreciate your effort in being here.

Chairman JACOBS. The Chair expresses the gratitude of the entire committee for the contribution of the panel and notes particularly the comments made about lag in price for home health care; it is a matter much on our minds. Others have brought it to our attention through correspondence, principally. I think it is included in the record at this point with our gratitude.

I might say, Mr. Smith, you did so in two and a half minutes, but the administration beat you. Dr. Rubin took two minutes this morning. Perhaps you weren't here, but we have offered a prize of $1 for the witness who testifies the most concisely during the day. So far the administration, having not very much to say, actually, wins the prize, depending on what happens with the Townsend plan, which is the next organization to be heard from. We thank the panel.

John Doyle Elliott is director of the Townsend Plan National Lobby. Mr. Elliott, welcome to the committee.

I am sure you understand our procedures.

STATEMENT OF JOHN DOYLE ELLIOTT, DIRECTOR, TOWNSEND PLAN NATIONAL LOBBY

Mr. ELLIOTT. Yes, Mr. Chairman. Thank you very much. I will try to summarize my statement, which I have submitted to you for the record, in 5 minutes. It only involves the background altogether in these social justice issues of 47 years; and on the health industry business dating back to 1947. Now——

Chairman JACOBS. If you care to be seated, you may be welcome to do so.

Mr. ELLIOTT. Well, I don't want to get too close to that thing. I don't want to ring the rafters overmuch here.

I would like to summarize it this way: From the point of view, first, of competition, we are living in an age of two kinds of competition, honest competition, the production of wealth and services, on the basis of that competition which delivers value for money received.

We are also living in the presence of another competition, a competition whose objective is to eliminate competition. We even have coming to light corporations buying up hospitals. This deals with the question of health insurance. The health industry is rapidly becoming the biggest of all industries because other industries are inherently becoming relevant to it and as science continues to advance that knowledge will result in the constant growth of the health industry.

I want to put it this way: Fundamental to this whole issue, not only of health financing and so forth, and justice, but to social justice in general, I think that hospitals are just as essential to this present and growing and "to-come" health industry as highways are to transportation, and that they constitute something. As an example, they constitute something vital already that cannot be trusted to the wrong kind of competition; namely, monopolistic competition.

Now we have these things going on. We have the farmers now following in the footsteps of the corner grocer, and the family farmer has about as much chance of competing with these great, growing corporate farms, as the corner grocer has had competing with the chain store developments.

Now, justice has two sides, a right side and a wrong side every time out. And this is a principle that is at large now in our country. We have foreign capital, as was brought out so emphatically in the press a week ago today and yesterday as a matter of fact, right here in town. Foreign capital coming in, buying up our lands, buying up the bankruptcies of farms, buying up smaller technological industries. It is the wrong kind of competition.

Above all things, the founding fathers laid down the priorities—life, liberty, and the pursuit of happiness. Nothing is more pertinent to life, let alone liberty and the pursuit of happiness, than this health industry that is coming about because of our investments in the advancement of science and its learning, which is accelerating, and I hope will accelerate beyond our dreams.

Now, my testimony is aimed at that reality and one other. Medicare is the only right thing that has been done yet under social security by the Congress, or this country. Medicare did not say to a citizen, "Your earnings records have not been so good, therefore you are only entitled to about one-half of health care," and to another, "You did pretty well, Joe, you are entitled to full health care, to a full, a complete appendectomy." No!

But that is what they have said about health in reality. Under Social Security, in regard to food, shelter and clothing, the basic essentials of life! I say to you there is nothing more vain—nothing more vain—conceivably, than trying to deliver health care to people who are having to live on standards which dictate sickness. That is what my testimony is all about. I hope you can find time to read it, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF JOHN DOYLE ELLIOTT, DIRECTOR, TOWNSEND PLAN NATIONAL LOBBY

Mr. Chairman, Medicare is national health insurance. Though, as yet, incomplete as such, its coverage extended to all our people is the prime road to fullest justice and success in regard to health—life its very self.

As scientific knowledge continues to expand, the health industry is rapidly becoming our largest industry. That expansion of science is accelerating; and its most meaningful results, directly and indirectly, are expansions of our abilities to maintain health—with other industries increasingly becoming part of the industry of health. Health, our most important form of wealth.

Medicare is the cornerstone principle of the health industry's most health insuring reality. Medicare's perfection with full coverage of all our people, fully, embodies the principles to achieve honest competition—the honest and just employment of all occupations and professions relevant to completed national health—life—insurance.

Up to now, Medicare is the most outstandingly right thing yet done in the name of Social Security. Medicare does not say to one American that his low record of earnings entitles him to insurance for only half a treatment—to only half an appendectomy, for example; while it tells another that his earning record is high enough to entitle him to a whole appendectomy. But, that is just what social security is still telling people in regards to their rights to the bare necessities of life—namely, food, shelter and clothing.

That, despite the reality that we have the problems of social justice because of our misfortuned—not because of the well-fortuned.

Therefore, let me make and record this judgment: Medicare provides for competition among providers of health services and needs very well. In Medical Service of D.C., Blue Shield Form 4C1-56003 Rev 7/79—in explanations and directions relative to Medicare payments to patients for services or supplies, item 5 states: "The amount Medicare may pay under law is limited to the lowest of the: (a) Actual charge for the service or supply. (b) Customary charge made by the physician or supplier in 50 percent of his billings during the base year. (c) Prevailing charge; i.e., the charge made 75 percent of the time by other physicians or suppliers for similar services in the area during the base year."

When full national health insurance for all our people from cradle to grave with no bills to patients is achieved, the incentives for honest competition between the professions, occupations and businesses involved in health services or supply can be accorded no more just standards and guides than above item 5 embodies. It's inherently, clearly definitive and encouraging of honest competition to deliver value for money received.

In view of the foregoing we can, conditionally, approve of the advocacy fostering competition in health service and supply, as presented in H.R. 850—except that we oppose any amendments, or changes in Medicare than its advance towards total, no-bills-to-patients, complete preventive and recovery national health insurance, cradle to grave, covering ALL our people fully.

Now that leads me to this consideration, as embodied in the enactment of Medicare under Social Security. The perfection of Medicare and the perfection of Social Security are inseparable in respect to their mutual essentiality to illness preventing and curing health care.

Nothing can be more in vain than health care for people on living standards which dictate sickness.

Now, some more about competition. At this point in history, we have another growing kind of competition—which is threatening to become a private, corporate form of own-everything socialism. In recent times, our family farmers have been fading away by legions, year by year. Their farms are being taken over by corporations.

In the end, our family farmers can no more compete with these corporate farms than the corner grocers have been able to compete with the mighty chain stores. Like vast California orange groves I first saw a few years ago—fenced by signs designating their ownership, by a mighty international oil company. Most family farmers can't command use of the mighty, hundred-thousand-dollar and up tools and equipment which mean no more than small change to corporations seeking something of incomparable value in the future.

A week ago, in the Washington Post, appeared a sharp report of opening studies under the Government Operations subcommittee of already vast holding of U.S. Stocks by members of the Organization of Petroleum Exporting Countries (OPEC). This most revealing article concluded showing the estimate that in the last 25 years Saudi Arabia's earnings from oil exports amounted to $369.9 billion; and that Saudi Arabian earnings in the next 8 years are expected to total $1.69 trillion. 4 times that in the past 25 years. Land, smaller technological businesses—whatever seems tied to the future—that illustrates foreign investments and competition right here with American business and labor—and basically made possible by American money via exorbitant oil prices. You know, that could well include getting ownership and/or control of American hospitals so essential to the future, biggest, mightiest industry, the health industry. We've seen corporate moves in that direction, in recent times.

Isn't it clear that these multiplying corporate ownerships are not just vastly rich American interests seeking to own everything possible (private socialism, if you see it my way.)—but, that they are also mightily growing foreign interests, including governments, among them already some very BIG ones in terms of money they have squeezed from US? American money? I think rightly so because—American oil interests (apparently not wishing to invest in the more costly development of our oil and energy resources) turned to oil-containing countries (so notably Arabia) for cheap labor to get oil to sell to us. With money received basically from American oil sold mainly to us, they developed those foreign oil industries, which Arabia took over; nationalized on Arabia's terms, it must have been, to have awarded Arabia the profits we now see her trying to use to gain ownership of U.S. businesses.

Therefore, I now urge that we greet enterprises under free enterprise and competition as the best possible economic method—best only so long as it's honest. That we all strive to be foresighted in striving to protect honest competition itself from greedy domestic and foreign competitors alike. To say nothing of the apparently financially growing, worse than greedy underworld.

Above all, protect our American health industry—the industry of life itself. Perfect Medicare by expanding it as rapidly as possible into total National Health Insurance, with no ownership for sale, vested in Uncle Sam only—in us. In all of us.

Right along with that, advance the "deferred wage"—namely Social Security's minimum benefits reflecting healthy-living-needs—never again to amount to living standards which dictate sickness. To me, that's the line of competition we ought to follow.

I believe that it's fully more than high time we get after the goals that should guide us.

Chairman JACOBS. Thank you for your contributions, Mr. Elliott. I hope the microphone didn't bite you. I understand your feelings. People have that. Your testimony is very eloquent. We are very appreciative of it.

Mr. ELLIOTT. Thank you. I would leave you with this word. I was right about the financing of social security 40 years ago, and I am hanged if I am quitting now.

Chairman JACOBS. You look like the sort of fellow who might have been right then. Thank you very much.

I will state for the record that we shall reconvene at this place tomorrow morning at 9 o'clock for the concluding day of hearings on so-called competition hearings.

[Whereupon, at 12:40 p.m., the subcommittee adjourned, to reconvene at 9 a.m., Friday, October 2, 1981.]

PROPOSALS TO STIMULATE COMPETITION IN THE FINANCING AND DELIVERY OF HEALTH CARE

FRIDAY, OCTOBER 2, 1981

House of Representatives,
Committee on Ways and Means,
Subcommittee on Health,
Washington, D.C.

The subcommittee met at 9 a.m., pursuant to notice, in room 1100, Longworth House Office Building, Hon. Andy Jacobs, Jr. (chairman of the subcommittee) presiding.

Chairman Jacobs. We resume the sitting of the committee for continued hearings on proposals to stimulate competition in the financing and delivery of health care. Prior to the recognition of the first panel, the Chair is disposed to recognize, in order, Mr. Gradison and Mr. Gephardt for a preliminary joint statement.

STATEMENT OF HON. BILL GRADISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. Gradison. Thank you, Mr. Chairman.

Today we will conclude 3 days of very important hearings on competition in our health care system. We have obviously heard diverging points of view, but there seems to be considerable agreement that our system does need reform. After reviewing the arguments for and against the competitive approach, I believe that introducing competitive forces into our health care system will be an important step toward controlling health care costs. Today, together with my colleague from Missouri, Mr. Gephardt, I will introduce the Voluntary Medicare Option Act, a bill which will allow medicare beneficiaries to receive a payment from the Government which they can use to purchase membership in a private health care plan.

Our plan will do much more than moderate health care costs. It will give medicare beneficiaries the opportunity to join plans that may offer them more services than they presently receive, at no extra cost. And, beneficiaries may be able to choose plans that offer exactly the benefits that they receive today, and receive a cash rebate. Either way, the consumer will be burdened with fewer forms and a lot less redtape.

Competition can certainly not be expected to solve all of our health care problems, but unless we move to change the present system, we will be burdened with a structure that includes no incentives for cost control. It is our hope that by introducing this bill we will encourage debate on broad reforms for medicare, and continue the discussion on competition that has been carried on at these hearings.

We have prepared more detailed information about this bill which is available here in the hearing room for those who are interested.

Thank you, Mr. Chairman.

STATEMENT OF HON. RICHARD A GEPHARDT, A. REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSOURI

Mr. **Gephardt**. Thank you, Mr. Chairman. I am pleased to join with Representative Gradison in announcing the introduction of this bill today. This, as many of you know, was the original part of H.R. 850, and we have tried to make it more explicit, to make it more specific and carve it out as a freestanding bill. It does not lessen my commitment in or interest in the other parts of H.R. 850, but I think indicates a belief that the time now is propitious for moving ahead on this particular piece of legislation. It is a way to begin to move into a world of complete competition and deregulation. I think we agree that in our present system where health care services are largely paid for by third parties, that neither the patient nor the physician nor the hospital has the incentive or enough incentive to be cost conscious. Our plan would allow medicare beneficiaries to start to receive care on a prepaid basis, thus giving providers incentives to hold down costs and consumers incentives to pick up the plan that best suits their needs. We allow medicare beneficiaries to opt into this system and to opt out if they wish to do that at a later date. So I hope the introduction of this bill today will add to this debate and this discussion of this most important area. Again I would like today to publicly thank the chairman of the subcommittee, Representative Jacobs, for making the opportunity possible for us to begin this discussion of this important issue, and I look forward to his continued leadership in this area.

Chairman **Jacobs**. I thank the gentleman.

The Chair will announce first that at 11:30 a.m. the committee will recess for 1 hour, reconvening at 12:30 this afternoon. The Chair will also observe that this third day of the hearings involves the greatest number of witnesses of any of the 3 days; the 5-minute rule, therefore, has to be observed carefully. When the 5 minutes is up for the presentation in brief, a bell will ring audibly, and the Chair requests that witnesses exercise the ingenuity and discipline to stop midsyllable. If there are further points to be brought out, they can be brought out during the questioning, as is frequently the case. I counsel the witnesses that in terms of the attention of the committee, usually the exchange of questions and answers adduces greater cognitive response anyhow. As is our custom, a $1 award will be made to that witness who is the most concise and testifies the most briefly.

The Chair announces that yesterday the administration, hands down, won the award of $1. The dollar has been dispatched to Dr. Rubin with our congratulations. We also concede that having nothing to say, it took not quite so long as other witnesses might have taken to say. So having said that, the Chair recognizes the first panel, including the American Medical Association, Dr. Fred C.

Rainey, chairman, Council on Legislation, accompanied by Ross Rubin, director, Department of Federal Legislation, and the American Society of Internal Medicine, represented by Dr. N. Thomas Connally, chairman of Governmental Activities.

Gentlemen, please proceed.

STATEMENT OF FRED C. RAINEY, M.D., CHAIRMAN, COUNCIL ON LEGISLATION, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY ROSS N. RUBIN, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION

Dr. **Rainey**. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, I am Fred C. Rainey, M.D., physician in the general practice of medicine in Elizabethtown, Ky., and currently serve as chairman of the Council on Legislation of the American Medical Association. With me today is Ross N. Rubin, director of AMA's Department of Federal Legislation.

INTRODUCTION

AMA has long been concerned about the increases in the cost of medical care and the growing share of gross national product being devoted to health services. It is important to state at the outset that all increases in medical care costs over the past two decades do not represent a problem but in fact reflect solutions to long-term public health problems such as high infant mortality and poor access to care.

Even though there are many factors affecting costs and even though improvements in the quality of care and of life have resulted, AMA has been greatly concerned about cost increases and has been actively engaged in activities designed to bring these increases under control.

AMA POLICY ON COMPETITION/CONSUMER CHOICE CONCEPTS

Mr. Chairman, the bills before the committee seek modifications, in varying degrees, in the health insurance and health delivery systems in order to bring about a reduction in national health care expenditures. While the bills have common elements, there are also vast differences in both approaches and consequences. The specific goals of achieving greater cost consciousness and individual responsibility in the selection of insurance coverage and in seeking health care are meritorious and should be pursued.

In June of this year, the AMA house of delegates adopted a report containing principles for evaluating competition legislation, should such bills be considered by the Congress. This report identified basic concepts as constituting the critical elements of a pro-competition/consumer choice proposal. These objectives could be accomplished through minimum modifications to the tax code. Such a procedure would allow for introduction of basic concepts of the proposals with minimum interference in the existing delivery system, at the same time providing visible application and demonstration as to the efficacy of the competition theory. In our view, this activity should be limited to the employment setting where the principles are easily adaptable, and where currently most persons have their coverage.

Accordingly, any legislative proposal should be aimed at carrying out the following objectives:

MULTIPLE CHOICE OF PLANS

Insurance coverage options should be available to employees; accordingly employers, through incentives, should be encouraged—but not required—to offer health insurance plans. If they choose to offer insurance, employees should have a choice from among multiple options.

MINIMUM BENEFITS

Health insurance plans offered to employees should contain certain benefits, including catastrophic coverage.

EQUAL CONTRIBUTIONS

Equal contributions should be made by the employer toward health insurance plan premiums, regardless of the plan selected by the employee.

NONTAXABLE REBATE TO EMPLOYEES

An employee should receive a nontaxable rebate where a plan costing less than the amount of the employer contribution is selected by the employee.

MINIMUM NONTAXABLE CONTRIBUTION LIMITATION

A limit—adjustable for inflation—should be placed on the amount of health insurance premiums paid by an employer which are eligible for tax deduction by the employer as a business expense. Amounts paid by employers in excess of this limit would be taxable income to the employee.

EMPLOYER NONCOMPLIANCE

Unqualified plans should not be eligible for tax deductions.

When considering legislation to implement the competition theory, however, it is important to point out that proposals should not be allowed to restrain the appropriate use of needed medical services. Such legislation, therefore, should not be used to create incentives to underinsure. Furthermore, no legislative initiative should be considered that would have the effect of rationing or lowering the quality of care in this country. Aside from the direct impacts of competition legislation, there are also many indirect ramifications which must not be overlooked. Such proposals must be evaluated in light of the total health care delivery system in this country—a system that is extremely complex with interdependent components.

OTHER CONCEPTS IN PENDING LEGISLATION

Legislative initiatives before the committee go far beyond the above listed objectives and could create an adverse impact on our health delivery system. We would urge the committee to reject any legislation that would increase Federal involvement in regulation of health care delivery, that would merely replace existing programs of regulation with yet another set of expensive and complicated regulatory dictates, or that would require undesirable restructuring of our health system. We would also urge rejection of preemptive Federal legislation that would adversely affect the existing balance between the Federal and State roles in regulating health care and remove protections designed for the benefit of the consumer. It is also important that any program to promote competition or consumer choice should not create or perpetuate preferential treatment, particularly through Federal mandate, funding, or subsidy, of any one particular mode of health delivery. Finally, individuals should retain their freedom to choose a provider of health care.

MEDICARE AND MEDICAID

Some proposals of the so-called competition approach would include the medicare and medicaid programs within their scope. The mechanism usually proposed is a voucher system.

Mr. Chairman, there are many problems involved in applying the so-called competition concepts to medicare and medicaid. These programs were established because of the unique characteristics and needs of the populations they were designed to serve. Rather than establish a program that would make radical changes in the major programs for these vulnerable populations, we believe it would be more appropriate to evaluate the impact of changes brought about in the employment setting.

CONCLUSION

Mr. Chairman, in the limited time available today, we have identified a number of issues in "competition" legislation affecting health care delivery, and have offered our views as to issues that this committee and the full Congress should consider with respect to any "competition" proposal.

While many economic theories appear reasonable on paper, human behavior does not always mirror theory and can lead to unexpected results. Radical changes in health care delivery should be avoided, as should any proposals that would serve to ration or lower the quality of health care available to the American public.

Mr. Chairman, we would be pleased to answer any questions the committee may have.

Chairman JACOBS. Thank you, Doctor.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION, PRESENTED BY FRED C. RAINEY, M.D.

Mr. Chairman and members of the committee, my name is Fred C. Rainey, M.D. I am a physician in the general practice of medicine in Elizabethtown, Kentucky, and currently serve as Chairman of the Council on Legislation of the American Medical

Association. With me today is Ross N. Rubin, Director of AMA's Department of Federal Legislation. The AMA is pleased to have this opportunity to offer its views on what has commonly been described as health care competition legislation.

INTRODUCTION

Mr. Chairman, to date three bills have been introduced in this Congress that carry the "competition" label: HR 850, introduced by Representative Gephardt; S. 139, introduced by Senator Hatch; and S. 433, introduced by Senator Durenberger. From our review of these bills, they are apparently intended by their sponsors to seek modifications, in varying degrees, in the health insurance and health delivery systems in order to bring about a reduction in national health care expenditures. While the bills have common elements, there are also vast differences in both approaches and consequences. One bill limits its application to the employment setting, providing for employee choice of health benefit plans. Another covers the employed population, providing for similar consumer choice, but also providing for amendments of substance to the Medicare program. A third bill would cover the entire population, including the Medicaid and Medicare populations as well. The latter bill, H.R. 850, contemplates an extensive restructuring of the health delivery and financing systems, as well as providing for expanded consumer choice. Additional features of H.R. 850 will be discussed later.

AMA has long been concerned about the increases in the cost of medical care and the growing share of gross national product being devoted to health services. It is important to state at the outset that all increases in medical care costs over the past two decades do not represent a "problem" but in fact reflect solutions to long-term public health problems such as high infant mortality and poor access to care. As the Surgeon-General pointed out in his report "A Healthy America," the American people have never been healthier. Access to quality medical care has now been expanded for many groups including the needy and the aged. In this respect, increased expenditures have brought benefits impossible to measure solely from an economic viewpoint. Moreover, increases in health care costs, in large part, stem from the inflationary conditions existing in the entire economy and from the sophisticated advances in medical technology which enable patients to receive an unprecedented high level of medical care.

Even though there are many factors affecting costs and even though improvements in the quality of care and of life have resulted, AMA has been greatly concerned about cost increases and has been actively engaged in activities designed to bring these increases under control. In 1976 the Association created the National Commission on the Cost of Medical Care. This Commission, made up of 27 leaders in the health field, government, insurance, labor and industry, spent nearly 18 months in developing 48 recommendations designed to reduce health care costs and improve health care delivery. Many of these recommendations are current AMA policy and provide for changes such as modifications to the tax code to increase consumer choice in health insurance purchases.

Physicians are indeed conscious of the high costs of medical care. Results of a recent survey show that physicians are modifying their practices to eliminate unnecessary tests and modify business practices. We are especially gratified, Mr. Chairman, because the AMA has exerted special efforts to call upon physicians to restrain the rise in health care costs. Also, AMA is one of the principal participants in a collaborative effort with other interested groups in a program designed to restrain increases in hospital costs.

In addressing the rising national expenditures for health, the proposals now before the Congress and those being considered by the Administration reflect the conclusion that there is an excess of health care services being provided and that this excess is caused by unrestrained demand brought about by third party payment for the bulk of medical care. The theory advocated is that consumers, given a choice in insurance coverage with added financial responsibility for individual decisions, would cause a modification in the use of health care services. Such legislation would affect demand for health services, whereas regulatory efforts to date have been aimed at the supply side of the equation. The theory assumes that for various reasons, including the tax-free nature of employer-provided health insurance benefits, individuals now seek more health insurance than they need, with low deductibles and little or no coinsurance. Therefore, it is asserted that they have no economic incentive to restrain utilization. It is then concluded that if the incentive to "over-insure" is eliminated or the individual is given an opportunity and an incentive to select less comprehensive coverage, that individual will be more cost-conscious in purchasing health care services.

Mr. Chairman, the goals of achieving greater cost-consciousness and individual responsibility in the selection of insurance coverage and in seeking health care are meritorious and should be pursued. When considering legislation to implement this theory, however, it is important to point out that proposals should not be allowed to restrain the appropriate use of needed medical services. Such legislation, therefore, should not be used to create incentives to under-insure. Furthermore, no legislative initiative should be considered that would have the effect of rationing or lowering the quality of care in this country.

Mr. Chairman, it should also be kept in mind in considering measures to reduce overall health expenditures, that with the aging of the American population and with technological and other improvements in the medical arts and sciences, health care expenditures could continue to increase if Americans are to be assured needed health services.

Aside from the direct impacts of "competition legislation, there are also many indirect ramifications which must not be overlooked. Such proposals must be evaluated in light of the total health care delivery system in this country—a system that is extremely complex with interdependent components. For instance, private insurance and federal programs indirectly cross-subsidize numerous socially beneficial activities, such as care for the poor, medical education and biomedical research. Thus, any dramatic shift of coverage by individuals purchasing plans that exclude coverage for services provided at public or teaching hospitals with large numbers of indigent or Medicaid patients would create major funding problems for those institutions. In addition, problems of adverse selection, among the population as a whole or among specific market groups, could place health insurance premiums out of the reach of the high-risk population. These are but examples of many issues which need to be addressed and adequately dealt with in order to ensure that any program does not create more problems than it was intended to solve.

AMA POLICY ON COMPETITION/CONSUMER CHOICE CONCEPTS

In June of this year, the AMA House of Delegates adopted a report containing principles for evaluating competition legislation should such bills be considered by the Congress. This report identified basic concepts as constituting the critical elements of a pro-competition/consumer choice proposal. these objectives could be accomplished through minimum modifications to the tax code. Such a procedure would allow for introduction of basic concepts of the proposals with minimum interference in the existing delivery system, at the same time providing visible application and demonstration as to the efficacy of the "competition" theory. In our view, this activity should be limited to the employment setting where the principles are easily adaptable, and where currently most persons have their coverage.

Accordingly, any legislative proposal should be aimed at carrying out the following objectives:

Multiple choice of plans.—Insurance coverage options should be available to employees; accordingly employers, through incentives, should be encouraged (but not required) to offer health insurance plans. If they choose to offer insurance, employees should have a choice from among multiple options.

Under current custom, an employer, either on his own initiative or as a result of collective bargaining, may offer one, or possibly two, health benefit plans. Where a choice is provided to an employee, this may include a fee-for-service plan and, where required by federal law, an HMO option. Often the principal decision-maker as to the level of benefits for a particular employee is the employer. Such a system does not necessarily reflect the needs of an individual employee. This problem is exacerbated because the unlimited tax-free nature of employer-paid health benefits often makes it more attractive for an employee to take remuneration in health care benefits instead of cash. The system often results in comprehensive coverage, with little or perhaps no real choices for the employee.

Minimum benefits.—Health insurance plans offered to employees should contain certain benefits, including catastrophic coverage.

This precept is intended to avoid the undesirable consequences which could result from being "under-insured." Such a provision would also help in diminishing the likelihood of an "adverse selection" process.

Equal contributions.—Equal contributions should be made by the employer toward health insurance plan premiums, regardless of the plan selected by the employee.

Nontaxable rebate to employees.—An employee should receive a non-taxable rebate where a plan costing less than the amount of the employer contribution is selected by the employee.

These provisions are intended to provide incentives to the employee in selecting plans to meet his individual needs and to avoid the overuse of the health delivery system perceived to result from over-insurance.

Maximum nontaxable contribution limitation.—A limit (adjustable for inflation) should be placed on the amount of health insurance premiums paid by an employer which are eligible for tax deduction by the employer as a business expense. Amounts paid by employers in excess of this limit would be taxable income to the employee.

Current tax law, which allows unlimited tax deductibility to the employer for premiums the employer pays for an unlimited exclusion from personal income to the employee, is considered to constitute an incentive for over-insurance. this provision would end any tax bias whereby health benefit contributions are more valuable to an employee than other forms of income.

Employer noncompliance.—Unqualified plans should not be eligible for tax deduction.

A provision of this type would augment the previous precept and encourage employers to offer plans enabling the employee to have a choice from among multiple qualifying plans.

OTHER CONCEPTS IN PENDING LEGISLATION

The foregoing concepts are basic to legislative proposals before the Committee. However, legislative initiatives before the Committee also go far beyond these and could create and adverse impact on our health delivery system. We would urge the Committee to reject any legislation that would increase federal involvement in regulation of health care delivery that would merely replace existing programs of regulation with yet another set of expensive and complicated regulatory dictates, or that would require undesirable restructuring of our health system. One of the primary goals of fostering consumer choice or the so-called pro-competition legislation should be an end to intrusive national regulation that creates rigid national standards that do not reflect local needs and circumstances. We would also urge rejection of preemptive federal legislation that would adversely affect the existing balance between the federal and state roles in regulating health care legislation that would nullify state laws or regulations in areas such as licensure, insurance, corporate practice of medicine and open staffing of hospitals should be avoided so as not to disrupt or interefer with these appropriate state activities designed for consumer protection.

Other cautions must also be stressed. It is important that any program to promote competition or consumer choice should not create or perpetuate preferential treatment, particularly through federal mandate, funding or subsidy, of any one particular mode of health delivery. A pluralistic system should be maintained and encouraged in a neutral public policy setting. The right of the patient to have freedom to choose his provider of health care must not be abrogated or restricted.

MEDICARE AND MEDICAID

Some proposals of the so-called competition approach would include the Medicare and Medicaid programs within their scope. The mechanism usually proposed is a voucher system under which the program beneficiary would receive a voucher that can be applied toward the purchase of health care coverage through private insurance.

Mr. Chairman, there are many problems involved in applying the so-called competition concepts to Medicare and Medicaid. These programs were established because of the unique characteristics and needs of the populations they were designed to serve. Rather than establish a program that would make radical changes in the major programs for these vulnerable populations, we believe it would be more appropriate to evaluate the impact of changes brought about in the employment setting. Medicaid may not be appropriate for application of the "competition" approach because of the unique problems of access to care facing the poor. The needy may be discouraged from seeking necessary and proper care because of potential financial disincentives. Likewise the medically needy become eligible under the program solely because of the fact they have already incurred expenses that have reduced their income to Medicaid eligibility levels. Under Medicare, knotty problems such as adverse selection, and the determination of the share of cost of medical care for the elderly that should be borne by the federal government must be addressed before any voucher or other system for transforming Medicare into the "competition" mode should be considered.

CONCLUSION

Mr. Chairman, in the limited time available today, we have identified a number of issues in "competition" legislation affecting health care delivery, and have offered our views as to issues that this Committee and the full Congress should consider with respect to any "competition" proposal.

We have pointed out above that proposals before the Committee embrace various sectors of our population. We believe it is important that any proposal to implement the concepts of "competition" in health care delivery should not cover the entire population but should initially address only limited sectors. A program that would encourage the offering of multiple health benefit plans in the employment sector, allowing for employee choice and the basic concepts identified above, would permit introduction of "competition" concepts with minimum interference in the existing system. These changes can be accomplished through tax code modifications. This would provide valuable experience to demonstrate the validity of the "competition" theory in health care.

While many economic theories appear reasonable on paper, human behavior does not always mirror theory and can lead to unexpected results. Radical changes in health care delivery should be avoided, as should any proposals that would serve to ration or lower the quality of health care available to the American public.

Mr. Chairman, the American Medical Association will continue to be involved in the review and public discussions of competition proposals, and we look forward to working with this and other Committees of the Congress in addressing the problems of increased health care costs.

Mr. Chairman, we would be pleased to answer any questions the Committee may have.

Chairman JACOBS. Doctor.

STATEMENT OF N. THOMAS CONNALLY, M.D., CHAIRMAN OF GOVERNMENTAL ACTIVITIES, AMERICAN SOCIETY OF INTERNAL MEDICINE, ACCOMPANIED BY RICHARD L. TRACHTMAN, GOVERNMENT AFFAIRS REPRESENTATIVE

Dr. CONNALLY. Mr. Chairman, I am Thomas Connally, a practitioner in the District of Columbia and a member of the board of trustees of the American Society of Internal Medicine. On my right is Richard L. Trachtman, our government affairs representative.

The American Society of Internal Medicine [ASIM] is a federation of 51 State component societies, including Puerto Rico, representing more than 17,500 physicians who are recognized by their training and experience as specialists in internal medicine. ASIM has spent considerable time studying and evaluating the procompetition approach to reforming the health care system. As an organization composed predominantly of practicing physicians, our primary interest is the likely effect of this approach on the quality of care available to patients. In our view, access to care, quality of care, and cost of care are inseparable components of the health care system. We support those aspects of the procompetition model that have the potential for encouraging high-quality care at reasonable cost. However, we are concerned that other aspects of this approach place too much emphasis on cost containment and too little emphasis on the quality of patient care.

At this time, we would like to state our broad evaluation of the procompetition concept, rather than address the specific bills currently being considered by Congress. Certain common features of the procompetition proposals are consistent with longstanding ASIM policy.

PATIENT CHOICE AND ECONOMIC INCENTIVES

Central to the procompetition model is the concept that employees should be able to choose from a variety of health insurance plans. Multiple choice of plans is consistent with ASIM's position in favor of a pluralistic health care system.

We have been on record since 1977 as favoring inclusion of greater patient cost-sharing in all Federal and private health insurance plans. Greater out-of-pocket patient cost would provide an incentive for both patients and physicians to question the necessity of expensive tests, procedures, and hospitalization, resulting in more efficiently and effectively provided health care. Unfortunately, insurers often have seemed reluctant to develop and market such plans. Consequently, we strongly endorse the concept of multiple choice of insurance plans, provided that at least one of the plans offered includes significant cost-sharing features.

The society also supports the concepts that employers should provide equal contributions to all health plans offered and that employees should be permitted to receive tax-free the difference between the cost of the policy selected and the employer's contribution. These would, we believe, create incentives for employees to select cost-effective insurance plans, such as those with significant cost-sharing features. We also endorse placing limits on the deductibility of the employer's contribution to insurance plans to discourage costly "first dollar" coverage.

ASIM is concerned, however, that these incentives, if not appropriately designed, may lead to adverse selection by patients; for example, low-risk patients may select the least expensive plans and chronically ill patients will select the more comprehensive plans. We believe that the insurance concept of spreading the risk must be maintained: procompetition legislation must be carefully designed to minimize or prevent this adverse selection, and if enacted, there should be careful monitoring to ensure that such selection does not occur.

Some proponents of the procompetition model, such as Stanford University's Alain Enthoven, have suggested that all physicians would organize into competing economic units modeled after closed-panel HMO's. They maintain that plan sponsors would negotiate with providers and care would be furnished through closed arrangements. In essence, patients' free choice of physicians would not exist. We believe that it is inconsistent with the procompetition concept—which emphasizes expanding the public's right to choose—to deny patients the free choice of physicians or legislate preference for a particular health care delivery system. We feel it is inappropriate for the employer to provide only closed arrangements in the choice of plans available to the employee. Consequently, we strongly believe that at least one of the health plans offered to employees must include free choice of physician and oppose any provision that would abrogate this right.

ASIM believes that the success of any procompetition proposal depends on the ability of patients to make rational choices, based on economic and health considerations among health insurance plans. To do this, patients must have access to accurate, easily understood explanations of the various options available. Procompetition legislation should specifically provide for the development of such information.

MINIMUM BENEFITS

A possible adverse effect of the procompetition model is that employees might be underinsured. As insurers compete to offer lower cost benefit packages, many vital services might no longer be offered. We believe that the Government should mandate minimum benefit requirements to protect employees from the danger of underinsurance. At a minimum, all plans should include provisions for: coverage of catastrophic expensive illness; coverage of physicians' cognitive services; coverage of medically necessary preventive services; and coverage of out-of-hospital services equal to coverage of in-hospital services.

ASIM has publicly supported the concept of health insurance for catastrophically expensive illness since 1974. We testified in support of such coverage before the Senate Finance Committee in March 1979. We believe that no American should suffer financial disaster because of the cost of health care, and now strongly endorse coverage of catastrophically expensive illness as a condition for Federal approval of any insurance plan.

It is also essential that all health insurance plans offered to employees provide adequate coverage for physicians' cognitive services. These are services in which there is direct contact between the patient and physician, examination and interviewing of patients. Physicians' cognitive—thinking—services involve the application, based on relevant knowledge and experience, of such skills as data gathering and analysis, planning, management, decision-making and judgment relating to the prevention, diagnosis, and treatment of health problems, as well as communication of such information to the patient. Health insurers historically have not covered such cognitive services as physical examinations and patient counseling or have reimbursed patients for them at a much lower rate than the technical procedures physicians also perform. This has occurred even though cognitive services are at least as important as procedural skills in the provision of patient care. It is self-evident that the correct application of procedures is totally dependent upon the initial cognitive skill of deciding what is wrong with the patient.

Better coverage for physicians' cognitive services is likely to result in a moderating effect on health care costs. By reducing the current perverse incentives for the performance of technical procedures, it could be expected that decreased utlization of costly tests and procedures of marginal value to the patient will result. It would create incentives for physicians to spend more time providing preventive health services to patients, such as counseling patients on modifying harmful health habits before they result in serious—and costly—health problems. Currently, these important preventive services are rarely covered by health insurance.

Attached is a white paper prepared by ASIM that explains in greater detail the roots of the current problem and points out the advantages of solving this reimbursement disparity.

Congress has an opportunity to correct the historical inequity in coverage for these important cognitive services by requiring that such coverage be included in the minimum benefit packages of all plans offered to employees. Conversely, the enactment of procompetition legislation could also result in decreased coverage of cognitive services if insurers—in an effort to lower premium costs and make them more competitive—apply a punitively high deductible to cognitive services performed in the ambulatory setting.

High deductibles for ambulatory services are likely to increase costs in the long run by encouraging patients to obtain services in a hospital that could be provided at lower cost in a physician's office. For example, patients might go to a hospital emergency room for treatment of non-urgent conditions rather than pay out-of-pocket expenses for the same service provided in a physician's office. ASIM strongly objects to any legislation that would result in inappropriately high deductibles for outpatient services which would penalize patients who use these services. Instead, we favor a reasonable across-the-board patient copayment for all services, regardless of the setting in which they are provided. Of course, copayment should not be required for catastrophically expensive illnesses once a certain level of expenditure were reached.

We believe that procompetition legislation must also provide for coverage of those individuals who currently cannot get insurance because of their employment or health status. The need to close the gaps in private health insurance has long been recognized. Unless carefully avoided, procompetition legislation might perpetuate these gaps. ASIM is currently studying alternatives for coverage of the medically indigent and will be prepared to address this important issue later.

We recognize that our recommendations on minimum benefits will require some increase in regulation governing the health insurance industry. However, some of the proposed bills have provisions that would allow an unacceptable degree of Federal regulation of health insurance and health care delivery. ASIM believes that all Federal health care regulation should be kept to the absolute minimum required to protect the rights and health of the public and assure access to quality care.

DEMONSTRATION PROJECTS

In the past, major changes have been made in health care financing without adequate study. ASIM believes that the procompetition model should be pilot tested in order to avoid adverse effects associated with hasty implementation. We recognize that it may not be legally possible to pilot test all aspects of the model, since the bills all require major alterations in the Federal tax structure. However, some aspects of the concept, such as requiring employers to offer employees a choice of health insurance plans and projecting administrative costs of conversion could be studied on a demonstration project basis.

SUMMARY AND CONCLUSIONS

In conclusion we would like to briefly summarize our support and concerns described above.

ASIM supports:

Expanding patient free choice of competing health insurance plans.

Reasonable provisions requiring patient copayment of services.

Requirements which protect the patient's free choice of physician.

Mandating equal employer contributions to all plans offered to the employee including tax-free payment to employees who select less expensive plans.

Limits on employer deductibility of contributions to health insurance plans.

Provisions to prevent adverse selection or skimming of low-risk patients.

Minimum regulation of health care insurance and heath care delivery systems, except that which is necessary to protect the rights and health of the public.

Federally mandated minimum coverage requirements, including provisions for catastrophic illness and physicians' cognitive services, to guard against underinsurance.

Appropriate provisions for coverage of the unemployed and uninsurables.

ASIM is opposed to:

A procompetition approach which places concern for the cost of care before concerns about access to and the quality of care.

Any provision which grants preferential treatment to a particular health care delivery system or systems.

Inappropriately high deductibles that have the effect of penalizing patients for seeking necessary and appropriate services, or negating the ultimate concept of insurance by causing adverse selection.

ASIM looks forward to working with Congress to develop and enact legislation based on these principles.

[An attachment to the prepared statement follows:]

Reimbursement for Physicians' Cognitive and Procedural Services: A White Paper

American Society of Internal Medicine
January 1981

Overview of the Problem

Putting a price tag on the value of physician services has always been difficult and complex. Before the advent of health insurance on a large scale, fees usually were worked out between the physician and the patient, without governmental or societal intrusion into this relationship.

However, this has changed with the growth of third party payors as the primary financing agents for most people's health care.

Third party payors require predictable payment rates which, when combined with actuarial projections, allow them to maintain adequate premium revenues. The enactment of Medicare and Medicaid intensified interest in how physican fees are established. As a result, fee arrangements are no longer considered to be solely the province of the physician and the patient. Reimbursement formulas were established to *standardize* compensation for physician services, through methods such as fee schedules and "usual, customary and reasonable" determinations.

Standardization, unfortunately, has had the effect of locking in historical inequities in compensation for various types of physician services. This is especially true of the value placed on physicians' cognitive and procedural services. Physicians' cognitive services involve the application, based on relevant knowledge and experience, of such skills as data gathering and analysis, planning, management, decision-making, and judgment relating to the prevention, diagnosis, and treatment of health problems, and communication of such information to the patient. These "thinking" services historically have been reimbursed at a much lower rate than the technical procedures physicians also provide. This has occurred even though *cognitive services are at least as important, perhaps more so, than procedural skills in the provision of patient care.* It is self-evident that the correct application of procedures is totally dependent upon the initial cognitive skill of deciding "what is wrong with the patient." The mind behind the pen, the hammer, the wheel—or the scalpel or catheter—has always been most important. Unfortunately, the historical inequity in reimbursing for cognitive services has resulted in a *system that fails to recognize the importance of physicians' "thinking" functions.*

Part of the reason for this historical inequity is explained by the fact that health insurance originally was created to protect patients from the high costs of surgical procedures. Expansion of health insurance benefits led to increased coverage for other procedural services such as laboratory tests and x-rays, but did not include coverage for equally important cognitive services. As a result, physicians began to place greater emphasis on charging for procedures, so that patients could benefit from their insurance. This historical disparity continues today, as is clearly demonstrated by the following:

1. Income Differentials Between "Procedural" and "Non-procedural" Specialties

Physicians who specialize in surgical/procedural specialties consistently earn more than physicians who derive most of their income from cognitive services. Net income data for 1978, as well as data on average work output by different specialties demonstrate that surgeons and obstetricians/gynecologists earn more than primary care physicians, even after earnings are standardized to an hourly basis.[1] A 1977 study similarly showed that the lowest earnings are shared by general practitioners, family practitioners, pediatricians, and internists—specialties that share a dependence on cognitive services.[2] Within the field of internal medicine, those subspecialists that require extensive use of procedural skills earn more than other internists. For example, according to a 1978 *Medical Economics* review the 1977 median income (after expenses) of cardiologists was about $11,500 more per year than the median for other internists.[3]

2. Compensation for Specific Services and Procedures

The disparity in reimbursement for cognitive and procedural services can also be seen in average compensation for specific cognitive and procedural services. Physical examination of the patient and history taking, services with which almost all physicians are to some extent involved, are far less remunerative than many of the procedures of surgeons, pathologists, radiologists[2] and other procedural specialists.

For example, Medicare-Medicaid reimbursement for a relatively simple office surgical procedure may be several times higher than that for a general medical visit which includes the cognitive services of complete history and physical examination.[4] Yet these cognitive services form the basis of decision making and the application of appropriate procedures. Office visits in comparison to surgical procedures are undervalued by a factor of between two and three, according to a 1979 study sponsored by the Health Care Financing Administration. On the basis of the time, skill, effort, training, and expense required to perform each service, the value of an initial diagnostic office visit to a specialist should be 21 percent of an inguinal hernia repair instead of the 10 percent now reflected in prevailing charges. This is more than a two-fold discrepancy between the comparative value of the office visit and the usual amount at which it is reimbursed.[5]

Primary care physicians are not alone with this problem. Surgical and procedural specialists also suffer from the disparity in compensation for cognitive and procedural services. Surgeons now earn 85 percent of their gross revenue for hospitalized patients from surgery, and only 12 percent from consultation.[2] On this basis, it appears likely that consultation—a cognitive service—is being undervalued in relation to the performance of a surgical procedure. Indeed, preoperative evaluation and postoperative evaluation historically have not been separately identifiable services, and generally have been considered of relatively small financial value when considered part of the total service. Similarly, pathologists receive relatively less reimbursement for surgical (anatomical) pathology where critical decision-making is essential than for clinical laboratory procedures that involve fewer cognitive skills.

One of the reasons that cognitive services often are not adequately reimbursed is the lack of descriptors in most insurance plans for "health counseling," "preventive services," and other cognitive services. Furthermore, even though Current Procedural Terminology (CPT) allows separate coding for different "levels of care," a technique that would permit primary care physicians to achieve appropriate payment for cognitive services, CPT still is not accepted by many insurers. Universal acceptance of CPT and proper use of the "levels of care" concept is clearly needed if cognitive services are to be adequately reimbursed. However, acceptance of CPT by insurers will not in itself solve the problem.

Benefits Of Reducing the Reimbursement Disparity

Although the inequity in compensation for cognitive and procedural services has been condoned, in varying degrees, by both insurers and physicians, ASIM believes that the time has come for a critical evaluation of whether or not this reimbursement disparity is in the best interest of patients. *A reduction in the disparity between reimbursement for cognitive and procedural services may help alleviate some of the major problems facing medicine, such as the high cost of health care, the maldistribution of physicians by specialty, and the growing perception that medical care has become "too impersonal."*

1. Costs of Health Care

It is generally recognized that one of the reasons for the high costs of health care has been the trend toward increased physician utilization of expensive tests, procedures, ancillary services, and hospital services. Although little is known about the effects of financial incentives on the ordering of tests and procedures, the use of these procedures may be increased because of the financial incentives that favor procedural over cognitive services. A recent paper suggests that the financial reward given technological services, as opposed to cognitive services, may be a factor in "over-utilization" of expensive procedural care.[6] The National Council on Health Planning and Resource Development, in its 1980 report "Productivity and Health," has advocated, as one means of increasing health-care productivity, that the disparity between payment for technology-intensive, ancillary procedures and payment for consultative services be reduced.[7]

We expect that this would result in an *increase in the appropriate use of cognitive services with a potential decrease in procedural services.* Although it is not possible to project accurately that total health-care expenditures would be reduced by this shift, there does seem to be a reasonable likelihood that a moderating effect on costs would result from encouraging and rewarding the application of thought rather than techniques.

2. Specialty Mix of Physicians

Even if a reduction in the reimbursement disparity for these services does not have a direct effect on the quantity of procedures ordered by individual physicians, there is little question that it will help bring about a more appropriate mix of primary care physicians and procedure-oriented specialties—which in itself would have a beneficial effect on costs, since procedure-oriented specialists utilize more expensive procedures than primary care physicians. A physician's choice of specialty cannot be explained by differences in expected lifetime earnings among specialties alone. However, one recent report concluded that the economic incentives that favor specialized over primary care practice tend to induce physicians to enter the more procedure-oriented specialties.[8] An earlier study similarly concluded that high fees for some procedures common to a given specialty tend to encourage an over-supply of such specialties.[2] The reduction of the disparity in reimbursement for cognitive and procedural skills should encourage *more physicians to enter cost-effective primary care specialties,* such as internal medicine, family practice and pediatrics, and fewer physicians to opt for the cost-generating procedural specialties.

3. Physician-Patient Relationship

As specialized training in technical procedures has become more financially valuable in comparison to cognitive skills, there has been growing concern that the traditional caring, personal aspects of health care are not receiving the emphasis they deserve. Physicians are asked to spend more time and effort on preventive health counseling, patient education, and direct communication with patients, yet all of these activities—despite their importance for both patient health and the maintenance of a constructive physician-patient relationship—are grossly undercompensated. Indeed, the physician who spends a significant amount of time counseling a patient on the hazards of smoking or other destructive health habits is likely to find that his patient will not be reimbursed for this service.

Since inadequate reimbursement for cognitive services may act as an economic barrier to the provision of personal, caring services, it can have detrimental effects on the doctor-patient relationship. A recent paper has suggested that the current reimbursement disparity has led to an "adversarial" relationship between physicians and patients that is reflected in the numbers of malpractice actions initiated against physicians.[9] To the extent that better reimbursement for cognitive services improves the relationship between physicians and their patients, a moderating effect on the number of malpractice suits filed, and the cost of malpractice premiums, can be expected to result.

A restructuring of patient reimbursement methods to allow adequate compensation for important cognitive services, such as counseling and preventive education, *would promote the kind of caring, personalized approach to health care desired by most patients and physicians alike.*

Conclusion

ASIM recognizes that reducing the disparity in compensation for cognitive and procedural services will not be easy. History and tradition favor the continued existence of this inequity. The difficulty in quantifying cognitive services and the natural resistance to change also creates obstacles to reform.

However, ASIM believes that all of these obstacles can be overcome if physicians and third party payors are committed to solving the problem. If we are to bring about a health care system that is more cost-effective, more caring, and more oriented towards "thinking," rather than just "doing," a reduction in the disparity in patient reimbursement for cognitive and procedural services is an important—and essential—step in achieving this goal.

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asim
american society of internal medicine
2550 M STREET NW · SUITE 620
WASHINGTON, DC 20037 · (202) 659-0330

Chairman **Jacobs**. Thank you, Doctor.

Mr. Gephardt.

Mr. **Gephardt**. Thank you, Mr. Chairman.

I appreciate both of your testifying today. Your testimony has been excellent. I have been having a useful debate with the AMA about H.R. 850 in their own publication and I appreciate that debate, and I am always struck by how much we agree in this area. I commend you for your statement on the changes you favor in the Tax Code and for your desire to have freedom of choice, which I strongly believe in as you know from the way we have constructed 850.

I would like to go at what I think our major disagreement is, that is this business of preemption of State laws, and try to restate I guess what is my position: That is, if we do not have some amount of preemption, if we go to this world of competition, State laws, we are likely to leave in place or have put in place comprehensive State regulation which would totally frustrate the effort to get this industry deregulated. I just wonder if you can think of a way or if you have a way to solve that problem without undoing the things that have been passed at the State level that have to do with quality which I think everybody would agree should be preserved.

Dr. **Rainey**. Certainly I do not have a magic solution to that problem. It is our view, however, that the licensing determination and the qualifications of practitioners can best be determined at the State level rather than at the Federal level.

We feel that the mode of practice and the area of practice should be determined on the basis of training and experience, rather than by national legislative fiat. The boards of licensure in operation at the State level better protects the public than any other approach that we can think of.

Mr. **Gephardt**. Will you agree with me if we leave in place rate review commissions or State regulation of that kind that we are really not going to accomplish what we want to accomplish?

Dr. **Rainey**. I am not really talking about rate review. I am talking about the licensure of professionals, determining what type of practice that I, as a practitioner, may or may not engage in. I believe that the system has proven most effective over the past and I would be very reluctant to see that changed.

Mr. **Gephardt**. Could you tell me the concern about the corporate practice of medicine? You have said in your testimony and on other occasions that State laws affecting or prohibiting corporate practice are very important to you. Can you tell me why that is the case and why that causes you a problem?

Dr. **Rainey**. Yes, I would be happy to. Perhaps I can use an illustration in my practice. I feel my obligation is to be concerned about the patient that I am treating at that particular time. I do not believe it would be appropriate nor in the best interest of my patients if I have to be concerned about the corporate view or the corporate attitude of practice, nor should I have to be worried about profits for stockholders. I feel that my primary and foremost concern must be the patient that I am treating at that particular given time. I feel that I have to be unhampered and unrestrained in making decisions, medical decisions for the benefit of that patient.

Mr. **Gephardt**. Dr. Connally, would you like to comment on any of that?

Dr. **Connally**. I am not thoroughly knowledgeable with the various State laws on corporate practice of the professions. Generally, I would say that we perhaps are attempting something that may change the delivery of health care greatly, depending on which economist you talk to. Some say it would not change it very much, and others that it will change it to a great degree.

Mr. **Gephardt**. We can be certain that neither of them know.

Dr. **Connally**. That is right.

I think if we look at things that we have done to our system, whether it has been medicare, the increase in private insurance, or the increase in the numbers of physicians—we practically tripled our output of physicians in the last 20 years or so—all these things cause unforeseen changes in the cost and quality of care. We do not know exactly what is happening. I think we have to move in a stepwise fashion in trying to achieve these goals. I think if we use the tax laws to try to alter some of the perverse incentives in health insurance that we have now, then that is a worthwhile and achievable goal. Let us do that, see what happens, see if the system gets better, and then look at some of these State laws. I think you ought to try to move into things gradually.

Mr. **Gephardt**. Thank you very much for your testimony.

Thank you, Mr. Chairman.

Chairman **Jacobs**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

I would like to briefly pursue with you, Dr. Rainey, this question of corporate practice. Perhaps it is a semantic problem I do not fully understand. In many States there are relatively large organizations providing medical service, operating as corporations, health maintenance organizations to be precise. Where do they fit into the framework of what you just said? Do you feel they should be outlawed?

Dr. **Rainey**. No, not at all. I do not view the health maintenance organizations as the type of corporate practice that I understand you to be making reference to. The type of corporate practice that as I perceive it would be a large company, a large oil company, some other company that would become involved in the delivery of health care. Then you have corporate policy that you have to be considerate of and I feel that is inappropriate in the practice of medicine. I do not believe that is the situation with an HMO.

Mr. **Gradison**. I want to pursue this just a moment. In other words, if it is an independent HMO it is OK, but if Sears Roebuck owns the HMO it is not appropriate.

Dr. **Rainey**. I am sorry?

Mr. **Gradison**. If it is an indepedent HMO it is OK, but if Sears Roebuck owns the HMO it is not appropriate.

Dr. **Rainey**. I would not want to refer to specific instances, but generally that is true.

Mr. **Gradison**. An oil company?

Dr. **Rainey**. I think that is true, yes.

Mr. **Gradison**. Thank you, Mr. Chairman.

Chairman JACOBS. Thank you, Mr. Gradison.

Mr. Rangel.

Mr. RANGEL. No questions, Mr. Chairman.

Chairman JACOBS. In that case, the committee expresses its gratitude to you doctors for your testimony.

Dr. CONNALLY. Thank you for the opportunity.

Dr. RAINEY. Thank you.

Chairman JACOBS. Messrs. Goldbeck, Carpenter, Shelton, and Ms. Osga, please come to the witness table. The Chair may have made an error of gender here. Nonetheless, would you be kind enough to proceed in your own way and identify yourselves and your organizations so as to avoid repetition.

STATEMENTS OF WILLIS B. GOLDBECK, EXECUTIVE DIRECTOR, WASHINGTON BUSINESS GROUP ON HEALTH, AND RICHARD WARDROP, CHAIRPERSON, TASK FORCE ON COMPETITION/CONSUMER CHOICE

Mr. WARDROP. I am Dick Wardrop, general manager of employee benefits for the Aluminum Company of America, located in Pittsburgh, Pa.

Alcoa has always been concerned about rising health care costs. That concern began to sharpen as far back as 1975, when we found that the company's health care costs had gone up 23 percent over 1974. From 1975 through 1979, our health care costs escalated at an annual rate of approximately 15 percent compounded. This translates into an increase from $37 million dollars in 1975 to about $70 million in 1979, without significant improvements in benefits.

Starting in 1975, we undertook a number of initiatives designed to reduce the growth on these health care costs. We developed a starter program to contain costs that met with mixed success, and was abandoned in 1977. We have been very active in regional health planning in communities around the country. We have had a health governance program since 1978 for Alcoans who are hospital trustees. About 30 Alcoans have completed the 1½-day program. In 1980 we undertook a 3-year hospital utilization study at our Tennessee operations with Dr. Dick Egdahl of Boston University. We are optimistic about this program. We believe it will provide valuable information that will be useful throughout the Alcoa system in our efforts to achieve better management of health care costs.

Alcoa has been involved with the Washington Business Group on Health since its inception. Earlier this year I agreed to serve as chairman of the group's task force on competition. This task force was established by the WBGH board. It has a number of important goals: (1) To determine the members' views on basic health concepts; (2) to analyze the potential impact of various proposals on the member companies and other segments of society; (3) to critique generic principles for administrative complexities and costs and to determine whether they will actually meet the goals of their advocates; (4) to assist in the education of other Washington Business Group on Health members; (5) to develop a Washington Business Group on Health Strategy, including our own legislative package if it seemed appropriate, and (6) to recommend meaningful positions to the policy committee and the board of the Washington Business Group on Health.

Before the first meeting of the task force on competition, we sent a questionnaire to all the members of the Washington Business Group; we asked them for information on how they felt about a number of issues around the competition model. The first question in the survey was, Do you think it is necessary to change the existing reimbursement arrangement in order to have significant impact on the Nation's health care cost?

Of the responding companies, 80 percent said, Yes, we believe that, in order to have significant impact on the Nation's health care costs we have to change the reimbursement arrangement that now exists.

The task force, which consists of approximately 30 companies, has met three times. At the first two meetings, we undertook to educate ourselves—to see if we could better understand what competition in health care really meant. We invited Walter McClure to the second meeting. He was with InterStudy, a Minneapolis group which has been deeply involved with health care matters.

As we began to understand the competition model, we kept coming back to the reimbursement issue. It became obvious that, if we are really going to have an impact on the Nation's health care costs, we are going to have to change this existing reimbursement arrangement. Perhaps one way is to get a significant number of our employees and dependents into alternate delivery systems—those with a different reimbursement arrangement.

Alain Enthoven in his book, "Health Plan," notes four principles of competition. The one we want to talk about is that people must have a choice of health plans. That there must be competing health plans.

We believe the availability of competing health plans is the element of competition that is going to take the longest to put in place. In most communities only a small number of people are able to choose among competing health plans; or there are no available plans. Therefore, we have zeroed in on a proposed action for the WBGH.

At the conclusion of our second task force meeting, we asked the attending companies to come back to the next meeting with an answer to this question: Is your top management prepared to make a commitment to articulate definitive corporate policy on: encouraging the development of alternative health care plans; enrolling a sizable population into such plans?

I posed that question to my own company in August at a meeting with the vice president of industrial relations, the vice president of human resources, and our president. They fully endorsed the proposition of getting a significant number of Alcoa employees and their dependents into alternative delivery systems.

At the third meeting of the task force on September 9, consensus was reached on the proposed action. The proposal was approved by the membership of Washington Business Group on Health last week. By no means have we yet reviewed all of the issues around competition. But we have identified that one issue that requires early action—the opportunity for multiple choice.

We will continue to study the other issues that revolve around the competition model. Questions of tax rebates, problems of equal contribution, problems of adverse selection, and others, are still to be addressed. But we believe we have identified the most urgent issue—without which real competition in health care is impossible.

At this point we see no need for legislative action to implement our decision. However, our task force will study existing legislative proposals in order to be in a position to respond to them.

There are, of course, many other initiatives and strategies that companies are employing to impact on health care costs. The task force on competition has identified only one long-term strategy.

In conclusion, let me emphasize that the business community—contrary to some reports—is deeply concerned about health care costs. The Washington Business Group on Health has a good record for supplying information to legislators and staff about the real world of corporate health care. The group is acting. The groundwork has been laid. We have identified a particular definitive action that member companies should take to make an impact on health care costs, and soon we will be developing a plan to implement that decision.

Mr. GOLDBECK. My name is Louis Goldbeck, executive director of the Washington Business Group. I must note the irony of having just heard that the most profitable and fastest growing industry in the United States has developed an aversion to business. I wonder if that is perhaps a little bit of a signal the competition may be working somewhat already. We as a group would certainly totally agree with the basic premise that the system must be reformed and of the alternatives moving in the direction of increased market forces for competition is absolutely the right direction to go, by far the best alternative. We disagree and I personally disagree with the survival of the fittest orientation that some advocates have indicated as the inherent value of competition. Responsible business leaders cannot ignore those who would never pass a cost-effectiveness test, the consumers for whom there will be no choice. There must be a concomitant national effort to close gaps and assure care for those in need, and this will inevitably require some new resources dealing with such issues as longer term care and aging. All competition is not good, and there are entirely too many examples of medicare institutions today such as Valley View Hospital in Arizona have responded to competition and indeed to market failure exactly what you would like to have happen by offering rebates for hysterectomies to try to fill legitimately empty beds. That is not the kind of competition that the business community is interested in supporting.

In your bills, multiple choice: Increasingly I feel employers feel that there is no mandate needed. The evidence is emerging from those that are conducting experiments voluntarily, and for the private sector there certainly is one truism, that is they will respond infinitely better if they follow the evidence of value from their own efforts rather than a legislative mandate. There is also clear evidence that people will shop when given alternatives. That is encouraging. Multiple carriers: That concept is not supported. I see absolutely no opportunity for it to be supported. The tax law shifts, again I see a certain irony here that those opposed to regulation are now so enthusiastic about regulation for employers.

The tax law shifts have engendered little support thus far in the employer community, particularly because of the overall issue of compensation and employee relations, less so because of any in-depth analysis of a particular problem with health care per se. There is a concern that the tax law changes if they are written not be written in such a way that employers would have virtually no choice but to drop out the benefits such as wellness programs that are those that have the greatest long-term impact on the system both economically and in terms of health status. There are also alternatives to raise cost-consciousness in the flexible benefit shared savings, third providers, primary care plans and others. We would note the tax cap is not an essential element of competition. It is a critical element if you want specifically just to reduce demand and increase governmental revenues.

On the point of medicare and medicaid vouchers, the employer community is not united in a particular position on this issue yet, though there is great skepticism and concern as to whether this will actually work out. The concept of providing a choice for that segment of this population that is free to choose that has those options because of their health status is commendable. You must recognize that indeed a significant number of these people cannot have choice. For them the choice is to always buy the increasingly higher option plan, an effort that cannot continue ad nauseam. We would strongly endorse the 95-percent reimbursement for getting people in these populations into alternative delivery systems. That is a legitimate choice that the Congress can certainly move on whatever it does with competition in a larger sense. We also must note this is one method of reducing Federal expenditures and shifting them onto private payers whose plans today for retirees require them to pay 100 percent of the supplement above medicare, so if you draw down medicare by whatever percent the private employer simply has to draw up their side of the equation.

Administrative costs, about which you asked, certainly the costs are not known and will not be for several years. The greater fear is in small business than in the large business. In the small there is going to be some particular point at which new administrative costs will cause small employers simply to not offer the plans at all; that is the cheapest way out. On the adverse selection point, there is much that is not known. There is no question there will be adverse selection because that is indeed one of the principles of competition. You are urging by the incentives built in, be they taxes, rebates, you are urging people to buy low. If nobody buys low the competition system has not achieved its objective. We feel strongly there is much to be gained in this area, there is not a requirement for strong Federal legislation at this point, that the trends are in the right direction, and the advocates of competition can feel proud of what they have accomplished in that direction. But the strong need for Federal legislation is not required at this point.

Thank you.

[The prepared statement follows:]

Washington Business Group on Health

The Competition Strategy for Health Care System Reform

Presented to

U.S. House of Representatives

Ways and Means Subcommittee on Health

Presented by

Willis B. Goldbeck

October 2, 1981

922 Pennsylvania Avenue, S.E., Washington, D.C. 20003 (202) 547-6644

My name is Willis Goldbeck, Executive Director of the Washington Business Group on Health, a membership organization of very large employers with interest in health policy. Sharing this presentation is Richard Wardrop, General Manager, Employee Benefits, of ALCOA, who is the Chairperson of our Task Force on Competition/Consumer Choice Health Care Plans. We are delighted that Jack Shelton of Ford Motor Company, a WBGH member, is also speaking.

As time is short and this is certainly only the first of many hearings on the subject, I've organized my remarks around:

A. Competition as a generic concept

B. Current thinking on specific components

C. Trends

The Concept

The health care system works exactly as we designed it, and works well. Professionally and technologically the world's best, it has also provided rapidly growing insurance coverage and has, as an industry, a rate of growth that the rest of our economy is struggling to emulate.

Given these positive factors, we must reach agreement on the problem, a common goal and a strategy for solution. Competition, or market forces, per se, does not clarify the problem, nor is it "good" in its own right, nor is it a complete strategy.

Let me posit that the problem is an unquantified sense that the nation is spending too much on medical care because 1) there are other needs that are deemed to be of greater import, and 2) because data does not demonstrate a commensurate return-on-investment by existing measures of health status. Compounding this dual problem is the pressure to assure even more people of access to care and demographics that virtually assure increased demand.

Looking for causes to 1), above takes one outside of the health sector and into national economic policy, defense and the need to reduce the deficit and balance the budget. On-the-other-hand, 2), above suggests that if we spend whatever is allocated to health differently, the outcome might improve, and the rate of cost escalation might decrease. It is in this domain that the perverse nature of the economic incentives placed before the delivery system become so apparent.

Employers generally agree that system reform has only three options:
1. more federalization
2. public utility model
3. increased market forces

Given these choices, the latter is the direction favored by our members.

We have also reached consensus that changing the present cost-based reimbursement system is the essential ingredient of overall reform. Further, as Dick Wardrop's statement makes clear, we have made a commitment to an action program for alternative delivery system development because without alternatives there can never evolve a meaningful market forces system.

Having arrived at these basic conclusions, it is necessary to turn back to the goal.

If the goal is to further a specific economic philosophy, such as unfettered competition, then we can build in no barriers to cost increases and would sanction

> people having care rationed explicitly by age, sex, income, or earnings potential. Finally, we would do nothing to assure medical education or the continued existence of care where in fact it cannot be cost effective.
>
> Alternatively, if the goal is cost management, then the competitive system can be designed with very specific controls that are not inherently "free-market". Instead of neutral reimbursement policy, the emphasis is shifted toward the types of alternative plans we want to see developed that will encourage more efficient and effective delivery of care.

Recently, some government and private competition advocates have identified one of the goals as the creation of a system based on "survival of the fittest". Research shows that 13% of the patients who are very high users are responsible for the same amount of hospital costs as the remaining 87%. Work by Schroeder, Showstack, and Schwartz has demonstrated that, two years after discharge, 34% of high cost patients had died thus suggesting the degree to which resources are expended upon those with little or no chance for ever passing a cost effectiveness test.

If accepted, the competition approach marks the end of health insurance as we now know it. The concept of spreading the high risk across a broad base soon disappears when the healthy can select wisely among low cost options while the old, poor, and ill have but one option to select.

While business is certainly supportive of cost effectivness, we are not advocates of any system that confuses cost effectiveness with cost shifting. Much of our elderly population, those with chronic illness and children with major birth defects will never constitute a market for which the private sector will compete. They are consumers without choice and no amount of competition or vouchers will change that fact.

Competition is worthy of support as a long term process for changing the economic incentives in health care. But, that does not imply blind support for all kinds of competition. Recently, Valley View Hospital in Arizona announced with pride, its new competitive system offering "generous cash refunds, free transportation, and free flowers". According to the hospital, they have patients for only 68 of 104 beds and the program is aimed at "people who have postponed elective medical procedures because of their costs." Claiming that the program is "innovative", the hospital is seeking "hysterectomies, mastectomies, or anything that can be pre-planned", and has extended the rebates to those who will use the emergency room or even outpatient care.

Business does not support that kind of competition.

Employers do not view competition as a viable short term strategy and are concerned that the concept may have its good features destroyed in a blizzard of false expectations that will never meet the electoral schedule. To the extent that a realistic blend of increased market forces and modified regulation can be achieved, it must be built upon an expanding base of public and private sector actions addressing the three primary components of cost: reimbursement, utilization, and capacity. To ignore any of these is to guarantee wasted resources.

Current Thinking on Components

Your offer to testify requested our reaction to several of the components of a competition approach which are common to the three bills now under consideration (HR 850, S. 139, S. 493) and which have been central to the Administration's deliberations.

The WBGH does not have formal policy positions on many of these issues. However, our meetings with employers all across the country (several dozen in the last eighteen months), the work of our Task Force, extensive consideration of the recent budget cuts, work on the development of local business groups, and our just concluded Annual Conference makes me feel that we can reflect the current state of our member's thinking.

Multiple Choice

Support for this concept is growing, especially as the experimental efforts by such firms as TRW, American Can, Sun, and Deseret Mutual Benefits Association produce evidence that other employers can use for program design, and to allay their fears of excessive administrative costs. The rate of growth is slow, from a public policy perspective, but rapid from the standpoint of interest in relation to hard facts. This movement does not need to be encouraged by governmental mandates. There would probably be a negative reaction should such a law be seriously considered. Incentives could be provided to encourage more experiments but the greatest — and proven -- incentive will be evidence of success within the employer community.

In the private sector, experimental programs are too young to have definitive data. However, they do clearly show that employees will shop — and move among plans — if given options. Equally clear is the fact that the traditional indemnity plan receives scant support. For example: The Deseret Mutual Benefits Association, which holds the plan for some 40,000 Mormon Church (and affiliated organizations) employees in Utah has just tabulated the first year experience of its new three-option plan.

- Plan 1 is the traditional indemnity plan
- Plan 2 is a SAFECO-like primary care physician program
- Plan 3 is a closed panel HMO

The first open enrollment period produced the following selection:

Plan 1	18%
Plan 2	75%
Plan 3	7%

Cost was not a major factor since the monthly employee contributions were:

Plan 1	$45.00
Plan 2	$50.00
Plan 3	$40.00

After one year, enrollees are facing an average premium increase of 9%, approximately half that of the national average. On a per plan basis, increases in the employee contribution are:

Plan 1	$5.00
Plan 2	2.00
Plan 3	12.00

The latter is mainly due to construction of a new facility and thus is not relevant for this discussion. However, it is relevant that the high risk patients quickly moved to the HMO because its coverage was much more comprehensive than the indemnity plan.

Multiple Carriers

This proposal is rejected as being unnecessary and more costly than valuable. For the employee, there is no value gained from having choices distributed across carriers. The issue is offering real choice among plans regardless of carriers. We urge you to write no law that lessens the incentive of either employer (in the case of self funded firms) or carrier to become truly competitive.

Tax Law Changes

Employers are very reluctant to support any change that would result in imputed income for employees. The objection is less pointed at health than at the broader concern for taxation of all employee benefits and the resulting employee/labor relations problems. A second concern comes from those who believe the collective bargaining system, not tax policy, should dictate the extent of employer contribution.

Still others doubt that the "tax cap" would have a significant impact unless set so low that nearly all benefit plans would be included. This, in turn, would be a strong disincentive to offer a health benefit in the first place, especially for smaller businesses.

If there is legislation, it should be constructed to avoid a tax-based disincentive to employers and employees who want to initiate the new health and cost effective benefits such as nutrition, alcoholism, fitness, well-baby care, mental wellness, and health education for dependents.

Administrative problems are extensive and serious equity issues are raised even if the "tax cap" were to be set on a regional basis.

Perhaps the most complex problem of all is caused by the dramatic premium differences that occur regionally and even within a single SMSA. The following examples are illustrative and are not exceptions:

- Ford's family premium is $215 a month in Michigan but on a national basis averages $165 monthly.
- The UAW plans range from a low of $119 a month in New Jersey to a high of $205 a month in Michigan.
- International Harvester, to provide a contrast to the Ford data, averages $150 nationally per month. Deere, a comparable firm with the same basic products as International Harvester averages $71.40 a month without dental...add $18.90 for their dental and $2.25 for vision care.
- Even among the auto companies in the same city there are significant differences:

Cleveland	Ford & GM have a $28 difference
Chicago	Ford & Chrysler have a $33 difference

- Regional variations for Honeywell and Standard Oil of California are approximately 20%.
- HMOs used by the employees of major firms also experience the types of variations that make establishing any national plan based upon HMO averages very impractical. For example:
    - Carter Hawley Hale, offering only Federally qualified HMOs, is experiencing costs of 10-20% above their indemnity plan premiums.
    - FMC, which has been a strong HMO supporter, finds the costs of an HMO in California 11.5% above their indemnity plan costs. Conversely, their Kaiser HMO enrollees in California experience costs 40% less than that same insurance plan. This would seem to suggest that everyone should enroll in that Kaiser plan. However,

it has been closed to new employer groups for two years and intends to stay closed for two more.

We would note that "tax caps" are not the only way to provide incentives for employee cost consciousness. Without any legislation employers are using such methods as:

- flexible benefit plans where credits that can be applied to non health benefits provide the incentive
- plans which share cost savings resulting from reduced utilization (Mobil Oil)
- preferred provider plans
- primary care physician plans
- wellness oriented insurance plans

Finally, the "tax cap" is a tax policy matter and should not be confused with competition per se. It does not, in and of itself, encourage greater competition among providers nor change the perverse incentives in the reimbursement system. It should be viewed for what it is: a strategy to lower the demand for the purchase of comprehensive health insurance benefits; and a strategy to raise government revenues.

Equal Contributions

There is increasing employer recognition that, in order for market choice to truly reflect employee preference, equal employer contributions make good sense. However, as employers discover the benefit not only of choice for its own sake but also of providing incentives to select the low cost options, then unequal contributions can create a desired bias.

Medicare and/or Medicaid Vouchers

Employers are not certain about the effects of a voucher concept and would be willing to encourage experimentation at both the federal and state levels. Giving the recipient more choice and making a potentially viable market from those for whom no private market now exists are attractive objectives. Vouchers could be a very effective measure to create an alternative delivery system market if the voucher were set at 95% for those plans and a lesser reimbursement rate for indemnity plans, a position which has been supported by the WBGH.

Support for a voucher system is tempered by the realization that the primary federal goal is not competition but rather budget control. By cutting the value of the voucher, the government can reduce benefits without answering to the user. This means increased costs to the beneficiary and costs shifted to the private payer.

Cost shifting is increasingly significant for employers since the last few years have seen a dramatic growth in Medicare supplemental health insurance plans. Last week, we surveyed a sample of our members on this issue. Currently 95% provide supplemental coverage; 73% pay 100% of the premium. Every reduction in Medicare reimbursement produces a concomitant increase in the supplemental. The employer's choices are: a) pay more, or, b) reduce benefits thus, once again shifting the cost to those least able to pay. It is ironic that some of those now most in favor of a voucher cap were the strongest opponents of the Hospital Revenue Cap proposals.

Vouchers may be good, but they can become a system for cost shifting unless Congress is willing to design an explicit bias for alternative delivery systems.

Administration

Any system reform entails new administrative costs. Several years would elapse before we learned if that cost was excessive. For small employers, the unknown is that point at which the cost becomes a disincentive to offer insurance. Large employers can adjust but will be much more receptive if change is based upon experimentation rather than more regulation.

Adverse Selection

This problem is a stepchild of the confusion surrounding the goal for competition. If the goal is simply a change in an economic system, then adverse selection cannot be called a problem. However, if the goal is cost management, then adverse selection presents a large unknown. Finally, if the goal is governed by any concern for equity, adverse selection is a very large problem indeed.

There appears little doubt that adverse selection will occur. In fact, that is an explicit objective of competition: get people to select less rich insurance plans unless really in need of care. Thus, if the system's incentives work, such as tax free rebates, adverse selection is guaranteed, even though we do not know either its extent or real impact.

Sun Company's experience found people leaving the traditional plan so fast that average hospital days per thousand for those who selected the low option fell from above 700 to below 300. High risk people are increasingly aggregated in the most expensive options ...options the cost of which can only go up as the base across which to spread risk narrows.

TRENDS

Any new system must be constructed with an awareness of the relevant trends with which it must interact if success is ever to be achieved. The trends below are organized by constituency groups and are selected to focus on those which have the greatest impact on the likelihood of achieving a competition-based health care system.

Employers

A. evolution from awareness to frustration to action progams
B. local coalition development
C. benefit redesign
D. education
    1) self
    2) employees
    3) hospital trustees
E. data system development
F. making utilization review work
G. creating new forms of alternative delivery systems
H. increasing multiple choice and cafeteria plans
I. supporting wellness programs
J. self insurance as a cost management tool
K. supporting new health planning mechanisms
L. experimenting with "consumer choice" systems to learn what works
M. supporting reduced regulation, but on an increasingly selective basis

Comment: Most of the employer actions are consistent with an emerging competitive system. However, there is also a trend toward establishing utilization and reimbursement policies that are no less regulatory than those devised by government.

Labor

A. greater acceptance that new definitions of both "health" and "benefit" are good for workers and need not be "take aways". The cost imperative is not limited to management.

B. philosophically are opposed to legislated competition; fear of reduced care for those unable to afford the winners of competition.

C. negotiated protection against added employee costs resulting from legislation (limits potential effectiveness of the tax cap).

Comment: Competition represents a total reversal of the health care philosophy supported by labor for the past 30 years. On a local basis, labor may find the results satisfactory, but only if the poor, and working poor are truly protected. The continuing health care cost increases may, in turn, renew pressure for a regulatory approach.

Physicians

A. recognition of mounting cost pressures and the over supply of physicians

B. explicitly opposed to real economic competition

C. still control vast majority of dollar flow in system

D. also leaders in alternative system development, appropriate technology, and utilization review, but not to the extent of significant market impact

E. barriers to the information needed for meaningful consumer choice competition.

Comment: The physicien is the controlling factor in health care costs. Recently intensified opposition to competition is a signal that competition may ultimately be an effective cost modifier.

Public

A. #1 social issue is health
    1) fear of cost
    2) real cost increases
    3) fear and confusion about environmental hazards
    4) access: gaps have not closed just because we stopped talking about them

B. self care/wellness/self-determination (i.e., death with dignity and home birth movements)

C. awareness of fallability of medical systems

Comment: The public knows nothing of the competition debate and what it hears sounds very threatening. On the other hand, growing knowledge about health is a big plus for consumer choice. To be effective, the competition system must provide the individual with information that currently neither the physicians nor hospitals want the consumer to have.

Government

A. cost shift for the appearance of budget management

B. search for waste & fraud

C. lessen or shift regulation

D. verbal but not budgetary support for wellness

E. reduce services

Comment: Government's desire to save money by cutting services and eligibility and by shifting costs should not be confused with the continuing real need to close gaps in health care coverage, nor the need to improve management of the resources that are expended. The private sector is not the answer to all health problems.

Insurers

A. some are much more responsive to requests for data, others remain barriers

B. competing on basis of cost management, not just claims payment; feeling real pressure from self insurance and third party administrators

C. investment in alternative delivery systems increasing as federal program declines

Comment: Competition, if successful, poses a very real threat to the insurance industry since it basically changes the product from one of underwriting risk to one of administration.

Hospitals

A. defensive economics: expand as much as possible in the transition period of relaxed regulation and incomplete market forces.

B. centralization
    1) mergers
    2) multi-institution systems
    3) proprietary corporations
    4) regionalization of services

C. ...balanced by decentralization through
    1) out-patient services
    2) marketing services to industry
    3) ambulatory surgery
    4) home care teams

D. competition...for
    1) acute care patients
    2) high priced specialty services without regard for quality
    3) industry dollars for wellness programs
    4) survival

Comment: Proprietary hospitals have every reason to welcome competition since it would reward those with the greatest independent financial strength. Overall a successful competitive system will cause many hospitals to close, and not just those that are duplicative or poorly managed. The more hospitals are forced to behave like businesses, the more costs will be shifted to the private payers and services will be denied to those who cannot pay.

Cautions and Conclusions

Let me be blunt: there is no significant support for federal legislation mandating a competition system.

The employer trends just described may not be adequate. Nonetheless, in our fast-slow society it is useful to reflect that these have all developed since 1975. I can think of no faster way to sidetrack this progressive momentum than to mandate change through legislation.

We need to build upon this momentum. Awareness of the need for reform and the existing cost pressures are incentive enough to assure Congress thet many employers will act.

I urge that you avoid the trap of creating a void which will inevitably be filled by even more unnecessary expansion: the wrong kind of competition. The transition era must be a realistic blend of responsible regulation; of improved governmental and private sector cost management; and market forces increased by evolution rather than legislation. During this time we urge Congress not to throw away the planning and PSRO systems and that a coordinated effort be launched to develop creative state level approaches to both these systems.

We have the capacity and capability to reform the system without mandates. We do not know enough to design a national perscription. The trends are all pointed toward increasingly effective reform at the local level. The magnitude of change needed is beyond that which can quickly respond to legislation for which there is no clear constituency. We are entering a period of 10-20 years in which our values, the ethos of our society, will determine health care system changes far more than any legislative or regulatory policy.

Washington Business Group on Health

A BRIEF INTRODUCTION

The Washington Business Group on Health is a membership organization currently enjoying the active participation of approximately 200 major corporations. Through this relatively small number of employers, we estimate that approximately 55 million employees, retirees, and their dependents receive health and medical benefits. As staff to the WBGH, our office primarily functions as an information conduit. We serve as the health policy staff for The Business Roundtable Task Force on Health. In locating, developing, and distributing our findings, we:

- seek to bring credibility, integrity, and utility to the health-related interface between business and government.
- identify, summarize, and relay timely, health-related information which will or could have an impact on the private sector.
- provide a forum through which corporations that provide health and medical benefits directly to their employees can explore issues of common interest, such as:
    - cost management
    - utilization review
    - access to needed care
    - appropriateness of treatment modalities
    - assisting in the development of local level business groups or coalitions
- respond to requests from Congress and/or the Administration to develop or express positions reflecting industries' concern with various health policy issues. We have on-going involvement with:
    - Emerging "market forces/competition/consumer choice" proposals
    - National Health Insurance
    - Health Planning and Utilization Review
    - Medicare and Medicaid Reimbursement Reform
    - State health insurance and program legislation and regulation
    - School health education and mental wellness
    - Aging
- conduct in-house surveys utilizing our membership as a data base. Former and on-going projects include:
    - "market forces" attitudes and analysis
    - private sector health promotion programs
    - corporate mental "wellness" initiatives
    - corporate cost management activities
    - alternative delivery systems
    - self-insurance
    - screening and testing programs, including those for occupational hazards
    - disability

Other activities include; coordinating some of our activities with various academic communities, especially the Boston University Center for Industry and Health Care; National Industry HMO Council; interacting with health services trade associations; representing business interests to the National Steering Committee of the Voluntary Effort (VE); serving on the Policy Advisory Committee of the JCAH; and providing consultations to various health services research projects.

The WBGH is an IRS approved 501(c)(3) tax exempt organization.

922 Pennsylvania Avenue, S.E., Washington, D.C. 20003 (202) 547-6644

WBGH MEMBERSHIP LIST
As of 7-20-81

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American Can
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E.I. duPont de Nemours
Eastman Kodak
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EDS Federal

FMC
Federated Dept. Stores
Firestone Tire & Rubber
Ford Motor

GATX Corporation
GTE Serv. Corporation
General Electric
General Foods
General Mills
General Motors
General Signal
General Tire & Rubber
Georgia-Pacific
Goodrich Company, B.F.
Goodyear Tire & Rubber
Gould Inc.
Grace, W.R.
Gulf Oil

Hanna Mining
Heinz, USA
Hellmuth & Assoc, C.T.
Hewlett-Packard
Hoffmann-LaRoche
Honeywell
Hospital Corp of America
Houston Natural Gas

Ideal-Basic
INA Corporation
Ingersoll-Rand
Inland Steel
Inmont Steel
Int'l Business Machines
Int'l Minerals & Chemicals
International Harvester
International Paper
INTERNORTH

Jack Eckerd Corporation
Jewel Companies
John Hancock
Johnson & Johnson
Kaiser
Kennecott Copper
Kimberly-Clark
Koppers
Kraft
Kroger Company

Libbey-Owens-Ford
LIFEMARK Corporation
LTV

Macy, R.H.
Manufactuers Hanover Trust
Martin Marietta
MCA
McDonnell-Douglas
McGraw-Hill
Mead
Melville Corporation
Mercer, William M. &
Company
Merck
Merrill-Lynch
Metropolitan Life
Milliken & Company
Mobil Oil
Monsanto
Montgomery Ward
Morgan Guaranty Trust
Motorla

Nabisco
Nat'l Chain Drug Stores
Nat'l Medical Enterprises
NL Industries
Norton Company

Occidental Life
Olin
Owens-Corning Fiberglas
Owens-Illinois

PACCAR
PPG
Pacific Gas & Electric
Penney, JC
PepsiCo
Pfizer
Philip Morris
Pitney Bowes
Pittston Company
Procter & Gamble
Provident Life
Prudential

Quaker Oats

RCA
Ralston Purina
Republic Steel
Revlon
Reynolds Metals
Rockwell International
Rohm & Haas

SCM
Safeway Stores
St. Joe Minerals
St. Regis Paper
Schering-Plough
Scott Paper
Searle & Company, G.D.
Sears, Roebuck & Co
Shell Oil
Sherwin-Williams
SmithKline
Sperry Corporation
Std. Oil of California
Std. Oil (Indiana)
Std. Oil Co. Ohio
Stanley Works
Staley, A.E., Mfg.
Stauffer Chemical
Sun Company
Sundstrand Chemical

TRW
Tenneco
Texas Eastern
Texas Gas Transmission
Texas Instruments
Time, Inc.
Tosco Corporation
Travelers

Union Camp
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Union Oil of California
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UpJohn
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United Technologies

Valley National Bank

Warner Lambert
Wausau Ins Companies
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Wheelabrator-Frye
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Wyatt Company

Xerox

STATEMENT OF JACK K. SHELTON, MANAGER, EMPLOYEE INSURANCE DEPARTMENT, FORD MOTOR CO.

Mr. SHELTON. Mr. Chairman, My name is Jack Shelton. I am manager of the employee insurance department of Ford Motor Co. In an effort to win your dollar award I have abbreviated my comments. However, I would like to have my entire printed statement included in the hearing record.

As one of the Nation's largest employers, Ford is a major purchaser of comprehensive health services for nearly 1 million active employees, retirees, surviving spouses, and their dependents. During the last 15 years, company health care costs have doubled every 5 years. Between 1965 and 1980, total costs increased from $68 million to over $550 million. While there are many reasons for this dramatic increase, including the introduction of some new benefits, the majority of the increase is attributable to inflation and higher benefit utilization. If we divide our total health bill by active employees only—those individuals producing the product to cover these costs—the average cost per active employee in 1980 was almost $3,350.

Health benefit costs are part of the cost of producing goods and services in the U.S. economy, including automobiles. Ford health care costs in 1980 represented over $290 per vehicle produced.

FOR ACTIONS TO ADDRESS PROBLEM

In an effort to reduce the rate of cost increase, Ford Motor Co. has expanded its cost containment programs and increased its involvement in community and private sector efforts. Many of these programs are initiated jointly with the UAW. Our approach is two-pronged: First, we have modified our benefit programs and insurance arrangements to increase market competition and provider and consumer cost consciousness; second, we have developed short-term programs designed to correct specific problem areas. Major company programs include: (1) Copayments for new health benefits; (2) HMO promotion; presently about 70 percent of Ford employees are offered the HMO option. We believe HMO's are such an important cost-containment element that we participated in a coalition effort to launch a new Detroit HMO in 1979. This HMO now has over 88,000 members, and we are beginning to witness its competitive influence on the Detroit health system; (3) programs designed to correct specific areas of abuse. These programs include utilization review, second opinion before surgery, model treatment review, preadmission testing and weekend admission control; and (4) participation on Blue Cross/Blue Shield and hospital boards and in community efforts such as health planning, certificate-of-need review, and reduction of surplus hospital capacity.

As our programs suggest, we believe the cost problem must be approached on several fronts. It is for this reason that Ford continues to participate in and promote programs designed to deal with specific problem areas. A notable example is the Michigan program to reduce surplus hospital capacity. Initiated in 1978 by a coalition of business, labor, insurers, and State government, this unique State program will result in an orderly phaseout over a 5-year period of 3,800 surplus hospital beds. The Governor in this year's state-of-the-State address acknowledged that over 1,000 hospital beds already have been removed or approved for removal.

COMMENTS/OBSERVATIONS ON COMPETITION MODEL

We concur with competition model advocates that greater incentives must be introduced to encourage cost awareness by consumers who demand care, hospitals and physicians who provide it, and insurance companies that finance it. At the same time, we do not believe that these incentives can be introduced, or the health care system changed, overnight. Thus, there may continue to be a need for short-term programs for specific problem areas.

In addition to the uncertainty as to when competition can be effectively implemented, it is unclear to us whether legislation is the best means of introducing necessary market reforms. While not prepared to address the details of any particular proposal, we are concerned that certain proposed legislative provisions could lead, for example, to interference in the collective bargaining process, increased employer costs, inappropriately complex administrative requirements, and unnecessary Government regulation. These technical and practical problems may make large-scale legislative reform of the health system extremely difficult.

In our view, the best course of action—and the most practical—may be to develop pilot programs to demonstrate that the principles of the competition model are sound and to obtain practical experience in terms of implementation. Working together, we believe public and private sector interests can develop these demonstration programs. The Federal Government's role should be to motivate and promote such efforts through: (1) Establishment of competition and cost consciousness as national health goals and their promotion in the health planning process; (2) issuance of a challenge to business, labor, providers, and insurers to achieve these goals. We believe private sector interests would respond to such a challenge. In Michigan, a new private sector coalition is attempting to develop a statewide program to test competition concepts; (3) promotion of HMO's by reducing unnecessary regulations, continuing public education, and supporting their development in selected target areas; and (4) participation of medicare and medicaid in pilot programs.

CONCLUSION

In summary, Ford supports reform of the health care system through the introduction of market incentives and competition, but we believe practical and technical problems make it extremely difficult to attempt to legislate the necessary reforms. The best course of action is for public and private interests to work together as partners on the development of competition demonstration programs. In Michigan, through programs such as hospital bed reduction, we have demonstrated that coalitions can work. Now is the time to expand coalition efforts nationally and test the competition model. The experience and expertise obtained from these programs can become the foundation for long-term reform of the health system.

Thank you.

STATEMENT OF ROBERT A. CARPENTER, MEMBER, HEALTH CARE COMMITTEE, CHAMBER OF COMMERCE OF THE UNITED STATES, MANAGER, HEALTH CARE COST CONTAINMENT, REPUBLIC STEEL CORP., ACCOMPANIED BY JAN PETER OZGA, DIRECTOR, HEALTH CARE, HUMAN AND COMMUNITY RESOURCES DIVISION

Mr. CARPENTER. Mr. Chairman, gentlemen, my name is Bob Carpenter, manager of health care cost containment for Republic Steel Corp., Cleveland, Ohio. I am here representing the U.S. Chamber as a member of its health care committee. I also have greatly abbreviated my remarks in view of the time restraints. I would also respectfully request that the full testimony as submitted be included in the record.

We are pleased to have a chance to speak to the issue of competition in health care.

PROBLEM: RISING HEALTH CARE COSTS

A major concern to our corporate members in providing health care benefits continues to be rising costs. Nationally the health care bill is approaching the astronomical sum of nearly one-quarter of $1 trillion. Business is concerned about this cost because it pays for roughly half the bill, through $60 billion in premiums for group health insurance and another $60 billion in taxes to support medicare and medicaid, paid sick leave, compliance with safety and health regulations, and other health-related items.

The competition model attempts to attack one reason for rising health care costs—overutilization fueled by subsidized health insurance—primarily by revising the tax code to limit the amount that can be spent tax free on health insurance. In addition, the competition model mandates that employers offer choices of health care plans with varying benefits and attendant costs. Employees selecting lower priced plans would receive rebates that would be wholly, partially, or not taxed depending on the legislation.

CHAMBER POSITION ON COMPETITION MODEL

The U.S. Chamber supports the development of a more cost-effective, competitive health care system that will enable all persons to have access to quality care at affordable prices. More competition in health care should have the same effect on health care that it has on the rest of the economy. It should provide choices to buyers, stimulate innovation by sellers, and ultimately result in more stabilized costs for both.

However, the competition model—despite its good intentions—will not achieve these objectives and may be counterproductive to the goal of an improved health care system. Indeed, it appears to be a contradiction of terms to attempt to regulate competition, when market forces best achieve this objective. Moreover, it appears that this legislation is an attempt to regulate the health care industry through employers, with employers bearing the lion's share of the burden while realizing very little, if any, benefit.

PROBLEMS WITH COMPETITION MODEL

There are a number of problems with the competition model. We have listed many of them in our written statement. We will only highlight some of the major deficiencies at this time.

The limit on tax-free benefits would complicate an already complex Tax Code with at best questionable results. For example, a single national limit fails to recognize differences in medical costs and health care plans. In many cases, companies pay widely varying amounts for the same benefits in different sections of the country. A limit that varies by region and other factors may be more equitable but difficult and costly to administer.

Such a limit may also discourage companies from continuing or beginning cost-containment efforts, especially if wellness programs or self-insured plans would not be considered qualified.

We also must recognize the reality of employer-provided health insurance, in that labor unions participate heavily in their development. You have already learned of organized labor's opposition to the competition model. You know that in many labor-management agreements, employers would be required to make up any costs that employees have to bear as a result of public policy such as a national health insurance program or, in this case, competition legislation.

Clearly, for many companies the competitive model has the real potential to increase, not contain costs as a result of a tax cap.

MULTIPLE CHOICES, UNIFORM CONTRIBUTIONS, AND REBATES

The competitive model also requires employers to offer several health care plans, pay the same amount for all plans, and give employees rebates if they select a lower priced plan.

There already is Federal and State legislation mandating that employers provide options in health care coverage. The Federal HMO law requires certain employers to provide a federally qualified health maintenance organization as an alternative to traditional health insurance plans. Many employers have gone beyond this requirement and are offering several HMO's, irrespective of Federal qualification. Another Federal law with this requirement is not necessary.

A uniform contribution by employers to all health care plans is a sound approach to cost containment, which would require employees who seek more comprehensive coverage to share in the extra cost of such benefits. However, mandating that employers return savings to employees who elect less than full coverage poses problems. For example, it could diminish business support for alternative health care plans such as HMOs by having to transfer HMO premium savings.

Multiple options also has the potential to produce plan hopping or adverse selection in insurance parlance. It is predictable that younger, healthier employees would opt for less coverage, leaving some plans with a preponderance of older or higher risk persons—an actuarially more costly and impractical situation.

MINIMUM BENEFITS: CATASTROPHIC AND CONTINUOUS

The competitive model also requires that employers provide certain minimum benefits, such as catastrophic coverage and coverage for periods of temporary unemployment. Again, Federal legislation for this purpose is not necessary and could have severe economic consequences on smaller employers.

For example, 93 percent of all new group health insurance plans written provide for protection against medical costs of $100,000 or more. Clearly, where employers are able, such protection is being offered voluntarily. Federal legislation for this purpose is not needed. You should know that according to some analysis, a mandated catastrophic plan could cost small employers as much as $800 per year per employee—clearly a cost-prohibitive arrangement.

Continuation of insurance coverage during layoffs is another benefit provided by those employers who can afford it. General Motors provides such protection for a full 12 months after such occurrences. But consider the smaller firm or the retail firm, with seasonal employees and high turnover. It is conceivable that such firms could have more persons covered for health insurance who are off the payroll than are on the payroll. Such a situation is simply untenable and should not be created by Federal legislation.

In conclusion, our members believe that competition exists only when buyers and sellers are free to negotiate for products and services. Better purchaser and consumer awareness of health services and their costs will help competition emerge in health care delivery. Federal legislation regulating competition is a contradiction in terms. Such legislation could well increase rather than contain costs and have the overall effect of reducing the number of persons protected against the high cost of needed health care.

We respectfully suggest that a better alternative is to create a climate in which private action is allowed to flourish. Sixty business coalitions for health action around the country are initiating community actions designed to come to grips with our cost concerns. These efforts do not require any legislation but merely the support of both the private and public sector to work together to find voluntary methods of containing costs.

Your support of such initiatives can provide the ultimate competition—the business coalitions developing strategies to solve the vexing problem of rising health care costs. The U.S. Chamber and other segments of the private sector are committed to helping this kind of competition thrive.

Thank you.

[The prepared statement follows:]

STATEMENT OF ROBERT A. CARPENTER ON BEHALF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES

Mr. Chairman: My name is Robert Carpenter. I am Manager of Health Care Cost Containment at Republic Steel Corporation in Cleveland, Ohio. I am also a member of the Greater Cleveland Coalition on Health Care Cost Effectiveness, one of 60 business coalitions on health action located around the country. I appear here today as a member of the U.S. Chamber's Health Care Committee, accompanied by Jan Peter Ozga, the Chamber's Director of Health Care.

We are pleased to be part of this panel assembled to express its views on competition in health care. This subject has become quite popular and this committee is to be commended for providing a forum for discussion, especially for those most affected, American employers. We oppose competition legislation as written and believe that voluntary efforts to instill more competition in health care will be more effective than the competitive model's regulatory approach.

PROBLEM: RISING HEALTH COSTS

Health care costs continue to soar and strain the public's ability to finance these services. In 1981, the nation's total annual health care bill may total one-quarter of a trillion dollars or about 10 percent of the gross national product. Expenditures for medicare are doubling every 5 years and, without new sources of revenues or reduction in services, this program will be bankrupt before the end of this decade. The medicaid program poses equally stiff challenges for the states. Employers, who account for about 40 percent of all private health expenditures, also search for answers to their rising costs.

THE CAUSES OF THE PROBLEM

There are many factors contributing to the soaring costs of health care, including: better and more costly health services, e.g., innovations in medical equipment and technology; malpractice insurance and defensive medicine practices are conservatively estimated to be about 6 percent of the total health care bill; inefficiency in the delivery of services for which little or no economic sanctions exist; and overutilization of the available services as a result of demand stimulated by medicare, medicaid and the incentives inherent in fee for service, cost reimbursement and third party insurance which typifies the health care system.

Thus, the competitive model address only one part of the problem—overutilization fueled by subsidized health insurance—and it is questionable whether such an approach will have the intended effect of containing health costs.

COMPETITION TAX INCENTIVES RATIONALE

Proponents of the competition model claim that the reason health care costs are so high is that so many people are using health services, in many cases indiscriminately. Such utilization is encouraged by health insurance, which pays for about 90 percent of all hospital costs and 66 percent of physician fees. Thus, the full cost of such services is masked by a third party.

Insurance is so widely available mainly because the tax laws allow employers to deduct health insurance premiums as a business expense and for employees to receive such benefits as tax-free compensation. In addition, up to $150 of health insurance premiums paid by the individual may be directly deducted on the federal individual income tax. The remaining cost of health insurance premiums paid by the individual may be included with other medical expenses for those who itemize deductions. Finally, out-of-pocket medical costs exceeding three percent of adjusted gross income can be deducted. Acording to the Congressional Budget Office, in fiscal year 1980, these tax deductions collectively amounted to $14.5 billion, $9.6 billion (66 percent) of which relates to employer contributions.

Proponents argue that a limit should be placed on how much can be spent on health insurance premiums. Less inexpensive plans will emerge with employees sharing more of the cost. If employers were required to offer three or more plans with varying benefits and costs, and if employees were given a rebate if they chose less expensive plans, employees might not overinsure. Further, for plans to be qualified for any deductions, they would have to include certain minimum benefits, such as catastrophic coverage and coverage for periods of unemploymemt.

Six proposals to promote competition in health care incorporating the above rationale were introduced into the 96th Congress. Three of these were re-introduced into this Congress. All are summarized in Attachment A.

CHAMBER POSITION ON COMPETITION MODEL

The U.S. Chamber supports the development of a more cost effective, competitive health care system that will enable all Americans to have access to quality at affordable prices. More competition should have the same effect on health care that it has on the rest of the economy. It should provide choices to buyers, stimulate innovation by sellers, and ultimately result in more stabilized costs for both.

However, the competition model—despite its good intentions—will not achieve these objectives and may be counterproductive to the goal of an improved health care system. Indeed, it appears to be a contradiction of terms to attempt to "regulate competition," when market forces best achieve this objective. Moreover, it appears that this legislation is an attempt to regulate the health care industry through employers, with employers bearing the lion's share of the burden while realizing very little, if any, benefits. An analysis of the major features of this type of legislation will illustrate these points.

LIMIT ON TAX-FREE BENEFITS

The competition model would set a cap on the amount employers could contribute to employee health benefits, above which the contribution would be considered taxable income to the employee. The presumption is that establishing a limit would encourage employers and insurers, in turn, to develop less expensive choices of health care plans and allow employees to select among these choices. Yet, experience suggests that employees would elect to receive the health benefit and be taxed rather than forego the benefit. Employee selection of group life insurance coverage is a case in point, since employees are now taxed for that part of the premium paid by the employer for coverage in excess of $50,000.

A single national tax cap also fails to recognize that health care costs and, correspondingly, health care plans vary throughout the country and among different age groups. For example, one large manufacturing company pays twice as much for the same set of benefits in one area of the country than it does in another. Thus, a single national limit on tax free employer contributions would be inequitable. A limit which varies by age, area, and other factors would be more equitable but difficult to administer by the employer and the Internal Revenue Service. Too, a single national cap would discriminate against workers in certain areas and against older workers. Indeed, such a provision could discourage employers from hiring older workers.

Limiting tax free employer contributions would increase taxes for employees who receive benefits above the limit, which will happen under numerous union contracts. Yet, making employees "whole"—exempt from bearing any cost of benefits—is a specific provision of various union contracts.

Establishing such an upper limit could reduce employer incentives to contain costs. Employee wellness programs and possibly self-insurance programs are two cases in point, since they may not be considered qualified plans. Although, in the short-term, these types of programs could cost more and exceed the limit, their long-term effects could result in relatively lower costs.

Establishing a single limit may jeopardize other areas of non-wage compensation, such as pensions, by subjecting such benefit contributions to taxation. This would discourage employers and employees from creating sound retirement programs. The same could be true for accident plans, disability plans, etc.

In short, establishing a national tax-free limit on employer-paid benefits will complicate an already complex tax code with questionable and possibly counterproductive results. Clearly, there is the possibility of higher costs to employers and employees, without creating a more competitive health care market or maintaining and improving the health of employees, their dependents which is the real goal of the health system.

MULTIPLE CHOICES, UNIFORM CONTRIBUTIONS, AND REBATES

Several other features common to the competitive model are the requirements that employers offer several choices of health care plans, that employers pay the same amount for each plan regardless of cost, and that employees who select any plan other than the highest price option would receive the difference as a rebate. The rationale for these features is that employees will have the option of selecting among a variety of health plans and will be rewarded for not overinsuring.

There already exists federal and state laws requiring most employers to offer choices of health care plans. For example, Public Law 93-222, as amended, requires that all employers with 25 or more employees offer a health maintenance organization (HMO) as an option to conventional health insurance. Many employers are not only following the letter of the law but have gone beyond and are offering several HMOs. Another law is not needed for this purpose.

Having employers contribute the same amount, no matter what the choice of health care plan, is an effective cost containment strategy endorsed by the Chamber. But mandating this feature is an intrusion into the right of employers and employees to bargain for the type and amount of benefits they want and the price they are willing to pay for them. Again, legislation is not necessary for this kind of arrangement.

Another counterproductive result of high and low options is the potential for adverse selection. For example, persons most in need of health care would be required to pay a greater portion of their health service costs. Also, certain comprehensive plan options (e.g., HMOs) may attract so many high risk individuals that they would be unable to compete with other plans. Thus, this approach would be counter to the purpose of the competition model.

Rebates to employees could also increase employer costs, especially for many employers who pay employee benefit premiums in full. In addition, rebates could diminish business' growing support for alternative health care plans, such as HMOs, by having to transfer HMO premium savings from the employer to employee. In addition, to compensate for younger employees choosing low cost plans, it could be advisable to compute an age factor into rebates. This would, of course, mean additional administrative problems, reduce the number of employees who select low cost plans, and introduce at least the perception of age discrimination into the health plan.

MINIMUM BENEFITS: CATASTROPHIC AND CONTINUOUS

Other features common to all competition plans are some sort of minimum benefits, the two most prevalent of which are catastrophic coverage and coverage during periods of temporary unemployment. Again, federal legislation mandating such benefits is unnecessary, given the current level of benefits provided voluntarily by employers.

For example, in 1979, over 93 percent of all new group policies written for health care included a major medical provision that paid $100,000 or more for catastrophic bills. A federal law requiring such coverage would simply add costs for reporting and administration.

Continuous coverage or coverage during periods of temporary unemployment is another common provision of most plans made available by large and medium size employers. However, mandating such coverage for all firms could have severe economic consequences for small firms and those engaged in retail trade. For instance, it is possible, given the high turnover among retail firms, that more former than present employees would be covered under an employer's plan. Such a situation would simply be unfair to any business.

In summary, employers aggregate premium and rebate cost may increase even if the rebate amounts are adjusted by age and area. Wages and costs of other plans may also increase. In addition some bills greatly diminish the role of the employer to negotiate, purchase, manage and administer a good health plan for employees. Too, some proposals create new federal bureaucracies and impose increased administrative burdens on employers. Such a situation is clearly counter to the mood of the country which elected the present Administration and Congress in the hope that such intrusion and burdens would be eliminated or at least alleviated.

According to Lawrence B. Huston, Jr., Assistant Vice President, Aetna Insurance Company, "Rather than rushing into legislation based on theory, we should test the theory. If part or all of the theory proves out, we can move quickly to implementation. And in fact we may not even need federal legislation, because employers and insurers will voluntarily adopt some or all of these proven pro competition consumer choice theories. But if part or all of the theory proves invalid, we will avoid costly precipitous changes with minimal benefits."

ALTERNATIVE: VOLUNTARY ACTION

In opposing the methodology, if not the concept, of "competition health legislation," the Chamber remains steadfast in its support for improving the health care system, including finding ways to contain its rising costs.

This interest was demonstrated over a decade ago when our Economic Policy Department highlighted various trends and developments in a white paper. This paper underscored the need for the private sector to monitor and evaluate the effectiveness of public health programs such as Medicare and Medicaid, as well as private health insurance plans.

This report was followed in the early 1970s by creation of the Chamber's Health Care Committee, which recommends policy on health care issues to the Chamber's Board of Directors.

By the middle of the 1970s, interest in national health insurance had grown, only to be tempered by a concern for rising health care costs. Clearly, the former had to be controlled before any discussion of the latter could be considered. At this same time, the Chamber decided to conduct its own investigation into the reason for rising health care costs and to determine how they could be contained. Accordingly, it undertook a comprehensive study of the issue that eventually resulted in its widely acclaimed Health Action program. The basis for this program is a series of action-oriented monographs that explains in what ways business is involved in health care and how it can contribute to improving health while containing cost.

The Chamber's Health Action program was implemented in early 1979. Since that time, over 60 local business coalitions for health action have been formed, at least 25 percent of which are sponsored by local or state chambers of commerce. These coalitions have a variety of memberships, sponsors and activities. However, all share at least one thing in common: they have been formed for the express purpose of seeking ways to help purchasers of health care services improve health care and contain costs voluntarily.

It must also be noted that all of these organizations, the number of which may double by the end of 1982, have been formed and are operating without governmental intervention or funding. They are the epitome of the principle that local problems respond best to locally developed solutions, since the developers have a major vested interest in these solutions.

The Chamber is currently involved in a project to help promote the growth and development of business coalitions, which will help them exchange their successes and failures with other groups or communities that are seeking to develop similar organizations. Part of this activity will help coalitions redesign health care benefits, become involved in health care alternatives, establish employer health education programs, and become more effective health planners, both on health planning agencies and hospital boards.

All of this activity underscores the need for the private sector to work together to find ways of containing rising health care costs, without resorting to governmental intervention including price controls or legislation that mandates benefits or limits such benefits through changes in the tax code.

CONCLUSION

Competition exists only when buyers and sellers are free to negotiate for products and services. Better purchaser and consumer awareness of health services and its costs will help competition emerge in health care. Federal legislation requiring competition is a contradiction in terms. Such legislation also could increase, rather than contain, costs as well as have the overall effect of reducing the number of Americans protected from health care costs.

A better alternative is to create a climate in which private action is allowed to flourish. This does not require any legislation but merely the support of the private and public sectors to work together to find voluntary methods of containing costs, such as through the coalition approach.

Perhaps the ultimate competition would be among the various business coalitions to develop various strategies to solve the vexing problem of rising health care costs. The U.S. Chamber and many other segments of the private sector are committed to helping this kind of competition thrive.

Attachment A

MAJOR PROPOSALS FOR COMPETITION/TAX INCENTIVE HEALTH INSURANCE

HEALTH INSURANCE LEGISLATION: Name, Number and Primary Sponsors / Provisions of Interest to Employers	COMPREHENSIVE HEALTH CARE REFORM ACT S. 139 Hatch (R-UT)	HEALTH INCENTIVES REFORM ACT S. 433 Durenberger (R-MN)	HEALTH COST RESTRAINT ACT Ways and Means Committee bill	MEDICAL EXPENSE PROTECTION ACT Martin (R-NC)	NATIONAL HEALTH CARE REFORM ACT H.R. 850 Gephardt (D-MO)	CONSUMER HEALTH EXPENSE CONTROL ACT Jones (D-OK)
	NOTE: None of these plans require any employer to provide health insurance to employees, *unless* they wish to deduct premiums as business expense and/or they wish to provide health benefits tax free to employees.					
EMPLOYER PARTICIPATION	All employers must offer plan with 25% copayment. Employers with *50* or more employees must provide catastrophic and preventative plans. Employers with *200* or more employees must offer a choice of 3 plans.	Employers with *100* or more employees must offer *3* plans written by *3* different carriers or prepaid health plans.	All employers who provide family health insurance whose premiums are *$75* or more per month.	ALL EMPLOYERS	ALL EMPLOYERS	ALL EMPLOYERS
EMPLOYEE PARTICIPATION	Employees not required to accept coverage.	Employees not required to accept coverage.	Employees not required to accept coverage.	Employees not required to accept coverage. *But*, if choose government plan, would pay 50% higher deductible than other eligibles.	Employees not required to accept coverage.	Employees not required to accept coverage. *But*, if choose government plan, would pay 100% higher deductible than other eligibles.
TYPES OF BENEFITS MANDATED						
• Basic	No	Yes	Yes	No	No	No
• Preventive	Yes	No	No	No	No	No
• Catastrophic	Yes	Yes	Yes	Yes	Yes	Yes
• Annual Deductible	20% of income	$3,500	$2,000	$2,500	$2,900	$3,500
• Continuous Coverage	Yes, 6 months	Yes, 1 month	NO MANDATE	Yes, 2 months	Yes, 3 months	May convert.
CHOICES OF PLANS All plans *encourage* choices through "REBATES" (See below)	No mandates but all plans must have 25% copayment for hospital services.	3 different plans written by 3 different carriers must be offered.	No mandate but HMO (group, staff, or IPA) *or* low cost insurance plan must be offered.	No mandate beyond one qualified plan.	No mandate beyond one qualified plan.	No mandate beyond one qualified plan.
FINANCING AND TAX LIMITATIONS						
• Tax Free Monthly Premium Limit	None specified	$125	$120	$120	Equivalent to average area premium of plans actually selected.	$100
• Premium Shared	No	No	No	Yes, employer pays 50% of least expensive plan.	Optional	Yes, employer pays 50% of least expensive plan.
• Equal Employer Contribution	Yes	Yes	Yes (approximately)	Yes	Yes	Yes (approximately)
TAX LIABILITY EMPLOYERS	*Employers*–premium contribution not deductible if paid for non-qualified plans.	*Employers*–no penalty	*Employers*-no penalty	*Employers*–premium contribution not deductible if paid for non-qualified plans.	*Employers*–no penalty	*Employers*–no penalty
EMPLOYEES	*Employees*–premiums taxed as income if paid for non-qualified health plans.	*Employees*–premiums taxed as income if exceed limit, paid for non-qualified plans, or 3 plans not offered.	*Employees*–pre-premiums taxed as income if exceed limit or paid for non-qualified health plans.	*Employees*–premiums taxed as income if exceed limit or paid for non-qualified health plans.	*Employees*–premiums taxed as income if exceed limit or paid for non-qualified health care plan.	*Employees*–premiums taxed as income if exceed limit or paid for non-qualified plans.
REBATES (difference between employer's contribution and cost of plan selected by employee)	*Employer*–No *Employee*–Yes, Tax free	*Employer*–No *Employee*–Yes, Subject to all wage taxes.	*Employer*–No *Employee*–Yes, Subject to income but not FICA or FUTA taxes.	*Employer*–Yes (25%) *Employee*–Yes (75%) Tax free up to $100 per year; excess subject to income but not FICA or FUTA taxes.	*Employer*–No *Employee*–Yes, Tax free up to $500 per year; excess subject to income but not taxes or FUTA. Tax credits also available.	*Employer*–No *Employee*–Yes, Tax free up to $100 per year; excess subject to income but not FICA or FUTA taxes.

INFORMATION AS OF MARCH, 1981. BILLS WITHOUT NUMBERS HAVE YET NOT BEEN INTRODUCED.

Chairman **Jacobs**. Mr. Wood, are you next? I apologize for not having called you, Mr. Wood. But I have called it twice now. Go ahead.

STATEMENT OF MARTIN D. WOOD, DIRECTOR, RETIREMENT, SAFETY AND INSURANCE DEPARTMENT, NATIONAL RURAL ELECTRIC COOPERATIVE ASSOCIATION, ACCOMPANIED BY C. STUART GRIGGS, SUPERVISOR, GROUP INSURANCE AND CLAIMS, CONTRACTS AND UNDERWRITING DIVISION

Mr. **Wood**. Thank you, Mr. Chairman.

Thank you, members of the committee. We appreciate the opportunity to appear. Appearing with me is C. Stuart Griggs, my associate.

I am Martin D. Wood, director of retirement, safety and insurance at the National Rural Electric Cooperative Association, which is an association made up of approximately a thousand cooperative organizations throughout the country furnishing electric power to rural areas; furnishing power in 46 States to approximately 25 million people. These organizations have about 40,000 employees, and we provide group insurance for those 40,000 employees.

I will not read my testimony, but I ask that it be included in the record.

My purpose in being here is simply to answer questions and also to emphasize the importance that we attach to this testimony. I shall merely touch some highlights of my written statement. The conclusions are that there exists today fierce competition among the group insurance companies. Twenty years ago an insurance company would not bid on coverage that was held by another insurance company. Today there are pitched battles to gain what are considered to be good cases. In our situation where we are a large group insurance buyer, we have seen that occur. We are talking about an annual premium of $30 million.

Group insurance was developed to help people afford medical coverage. One of the ingredients, one of the main ingredients for group insurance was simplified administration. The proposed bills would increase administrative expenses, thereby decreasing the value of group insurance and increasing the cost of medical care. The plans which we have at the association are so-called self-funded. This was done in order to reduce the costs to the employees and obviously reduce the cost of medical care. The proposed bills would eliminate the opportunity to self-fund. This would mean we would have an increase in cost which would approximately double the current expense. We estimate that the increase would be about 6 percent of the annual premium. We currently are able to carry that very nicely. I should mention that approximately 30 percent of the Nation's work force are insured under self-funded plans. It is a very important aspect.

H.R. 850 is particularly harmful to trusts and self-funded plans because it opens the plan to the general public . There would be no incentive for the employer to hold costs down. Further there is a requirement under a 501(c)(9) trust that no more than 10 percent of the participants shall be nonemployees.

The bills would have the employee choose the most advantageous plan and also what kind and how much medical care was needed.

How many employees will make the correct choice, and how will that really cut medical care costs?

Taxing the employer or limiting tax deduction for the employer may increase revenues, but we also question how that, in the long run, will really reduce medical costs. Cash refund or tax avoidance will entice some to choose inadequate coverage, and this may result in either economic disaster or serious physical problems.

In summary, we applaud the efforts to bring the rate of increase of medical care costs in line; it certainly is necessary. These bills attempt to accomplish this through administration. The impact of these bills would be on the smaller piece of the problem, namely administration, and we believe the impact would be seriously on the negative side. We feel we should be concentrating more directly on the source of the problem; namely charges for medical services. The encouragement of HMO's was a great step in that direction. It indeed brought an alternative method of delivery of medical services, which in our judgment is the essential ingredient.

Thank you very much for this opportunity.

[The prepared statement follows:]

Statement of Martin D. Wood, Director, Retirement, Safety and Insurance Department, National Rural Electric Cooperative Association

Members of the Committee, my name is Martin D. Wood and I am Director of the Retirement, Safety & Insurance Department of the National Rural Electric Cooperative Association.

This statement is presented to you to express the concerns of NRECA's Group Benefit Trust with reference to proposed "pro-competition" bills H.R. 850, S. 139 and S. 433 introduced in the 97th Congress.

NRECA is a national trade association of the more than 1,000 rural electric systems providing central station electricity to 25 million member consumers in 48 states and 2,600 of the nation's 3,100 counties.

NRECA member cooperatives employ over 40,000 individuals who participate in Association-sponsored group insurance programs. NRECA is a non-profit organization, and insurance benefits are provided solely as a service to our members. The group medical benefits, while underwritten by a major insurance carrier, are administered by the Retirement, Safety & Insurance Department.

We would like to emphasize that while provisions of the bills impede the ability of NRECA to administer these programs in the most efficient manner, the negative effects are borne by the participants and it is in their behalf that our comments are offered. We would also emphasize that the impact of these bills will not apply uniquely to NRECA, but will affect all plans which are covered by the various bills to some degree.

MULTIPLE PLANS AND "AREA ENROLLMENTS"

The NRECA Group Benefits Trust has taken advantage of favorable financial arrangements which would be devastated by any requirement to offer multiple insured plans such as mandated by S. 433. The "Minimum Premium Plan" under which Trust benefits are largely self-funded is an important example.

Self-funding enable Trust to minimize state premium taxes and the risk charge every insurance carrier builds into rates. Self-funding also allows our Trust to hold both the funds used to pay current claims and the reserves for future claims and earn a higher rate of return on investments than insurers offer. In favorable years, this allows the Trust not only to cover administrative expenses, but actually help offset the cost of medical expenses. In 1980, loss of the advantages of self-funding would have cost our participants approximately six percent. The national impact would be significant based on Library of Congress records which indicate that 30 percent of the nation's work force now receives health benefits coverage by means of self-funded plans.[1]

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[1] Samuel X. Kaplan, President, U.S. Administrators, Inc. Presentation to Statewide Health Care Costs Committee California Chamber of Commerce, March 2, 1981

All of the proposed bills either require or encourage multiple plan offerings which would render many proven cost control measures ineffective. At the onset, economies of scale are sacrificed and the risk pool fragmented. Risk charges for current claims and reserve requirements for future claims become an increased percentage of the funds used to pay benefits. Multiple plans result in a mix between group arrangements and individual plans and one has only to compare the costs to appreciate the savings group participants enjoy.

Proponents of these bills should recognize the additional administrative expense multiple option plans would incur. We estimate increased expenses of two to three percent for our Trust; however, the proportional increase in expense will be higher for smaller groups of insureds. Under a multiple option arrangement employers must: contract with the various insurance carriers; maintain multiple sets of records for accounting, payroll, rebate and tax purposes; incur the expense of issuing multiple plan descriptions; and become conversant with multiple benefit plans and be able to communicate the options to their employees.

All of these requirements increase the one element of the total cost of the program over which the plan administrator has some control—administrative cost or overhead—which does not benefit the employee in any way. It simply reduces the amount of money available to pay claims and therefore increases the ultimate cost of medical care protection.

The concerns with multiple options notwithstanding, H.R. 850 would appear to be even more damaging, especially when considering trust arrangements and self-funded plans. This bill requires that any person residing in the area of a plan be given the opportunity to enroll. Most employers realize that their employees ultimately bear the entire cost of the medical treatment they receive. The expenses the employee does not pay out-of-pocket are reimbursed by insured or self-funded plans and the premiums or contributions for those plans represent foregone wages from the limited amount of money the employer can allocate to employee benefits.

H.R. 850 would effectively remove the employer, a knowledgeable party who currently has a vested interest in minimizing costs, from the process. Basically the employer would determine the amount he is willing to contribute and step aside. He has no incentive to institute financial or other cost saving arrangements because his costs are fixed in advance based on a uniform contribution to the various plans within the area. Who would be willing to self-fund a plan and assume the administrative burden and risk of excessive losses if the enrollment in such a plan included a sizable population with no relationship to the plan sponsor?

It is also important to note that under IRS requirements a Trust such as ours is limited to a "non-employee" enrollment of ten percent.

All of these bills go to costly measures to provide the employee with the option of choosing between plans and assume that two difficult decisions can be made correctly and thereby reduce costs. The employee must: make the most advantageous choice of plans; and make the proper decision as to what kind of and how much medical care is needed.

If the individual is able to make the first decision correctly, the result would be a maximizing of utilization of plan benefits thereby causing higher costs for the plans as a whole. If the individual is not able to make the most advantageous decision and there is no effect on utilization, there seems to be no point in going through the exercise. In neither event is the total cost of medical services reduced.

In the second instance we now, and in all likelihood will continue to, depend on the physician to determine what expenditures are medically necessary. How often can we realistically expect the physician's judgment to be questioned when a test or procedure is recommended?

Although the size of the federal work force makes for a more favorable climate than the typical employer will have, something of a parallel to the multiple choice arrangement currently exists for federal employees who now have the option of participating in a number of different plans. A study of these plans may help answer several important questions. Can it be demonstrated that this choice has resulted in sharper competition and savings for those plans? Do federal employees comparison shop for health care? Are their costs lower than those for comparable benefits offered to other groups of insureds of equal numbers? What percentage of increase in costs have these plans required over the past several years? How much money, now spent for duplicated administrative expenses, could be applied to benefits with fewer plans and larger enrollments?

TAXATION OF HEALTH CARE CONTRIBUTIONS

The provisions of the various bills which begin taxing contributions by the employer not taxed before are out of place in a bill intended to contain the cost of health care. This tax is just an added burden to those who currently protect themselves. It will increase tax revenues, and the revenues may somehow be used to provide coverage for the indigent. This appears to be a well-intended effort to use the Tax Code for social reform, but the increased demand on the supply of medical services by those individuals will not serve to reduce the cost of health care.

Under bills S. 139 and S. 433 small employers (groups of less than 100 or 200) are not subject to these provisions and we have the inequity of a personal income tax based on nothing other than the number of employees of the organization for whom the individual works. If small groups are exempt from other parts of the bill, but subjected to such a tax it could hardly be imposed in the name of cost containment. These employees would not have the opportunity to enroll in a less expensive plan to limit their tax liability. At the same time it seems ludicrous to subject employers of two or three employees to the problems and expense of multiple plans assuming that willing underwriters can be found.

It is not difficult to imagine that some employees will be enticed by the opportunities to pocket a cash refund or to avoid a tax and thereby choose a plan which covers a smaller percentage of the medical expenses they may incur. Cost-sharing is a recognized deterrent to utilization of medical services and is found in virtually all existing plans, but the ideal portion of the medical expenses any particular employee should bear out-of-pocket is anybody's guess. If the burden is too great preventive care may be sacrificed or a serious condition may go untreated. We further see little sympathy on the part of the attending physician to reduce his charges when his patient uses his employer's contribution, intended for health care protection, for other purposes.

If the plans now in existence are any indication, our members, and much of the public have already weighed the cost of protection against "personal self-insurance" and seldom is the demand for a lower cost at the price of less protection. Large medical expenses can wipe out family assets, and most of us can reasonably budget for such an event only by way of comprehensive health care plans.

SUMMARY

Each of these bills assumes that employers, insurance carriers, third party administrators and employees exert considerable influence over medical charges. Our experience tells us this is not the case.

While we completely agree that the cost of medical care is increasing at an unacceptable rate, this should not be confused with the cost of providing the services to pay claims once the charges have been incurred. We believe that the main impact of these bills is on the cost of providing administrative services and the impact is to increase the cost of these services.

Chairman JACOBS. Thank you, Mr. Wood.

Mr. Gradison.

Mr. Rangel.

Mr. Gephardt.

Mr. GEPHARDT. I have one question. Excellent testimony on everyone's part.

Mr. Shelton, we have conversed before, and you pointed out a fact to me that I thought was very interesting about the number of your employees nationwide who are in a situation where they can take advantage of an HMO. Would you care to make that statement?

Mr. SHELTON. Presently 70 percent are in areas where we have HMO's that we have approved for offering to our employees, and probably another 10 percent in areas that would have access to HMO which have not been approved by the company. At the present time 70 percent of our people have access to HMO's, as an alternative.

Mr. GEPHARDT. Mostly in urban areas?

Mr. SHELTON. The concentration would be in the Michigan area, but we are spread across the country.

Mr. GEPHARDT. Thank you very much. Excellent testimony.

Chairman JACOBS. Mr. Duncan.

Mr. DUNCAN. Mr. Wardrop, do you have extended benefits for your employees when they are out of work or retire, health benefits?

Mr. WARDROP. Yes, we have benefits for employees both in layoff, depending on their length of service, but for up to 2 years extension for longer service people in layoff, and we have a continuation in retirement, two different plans, one before they are eligible for medicare, and then a supplement plan to medicare once they become eligible for medicare.

Mr. DUNCAN. In the automobile industry how long are benefits extended?

Mr. SHELTON. The company continues to pay the full cost of coverage for an employee up to 1 year depending on his eligibility. We also cover retirees and surviving spouses of deceased retirees, for lifetime, full cost.

Mr. DUNCAN. Thank you.

Thank you, Mr. Chairman.

Chairman JACOBS. Mr. Carpenter, when you referred to Federal requirements for competition, that is, a choice for employees among health plans, I assume you were referring to the HMO legislation.

Mr. CARPENTER. Yes, Mr. Chairman, I was.

Chairman JACOBS. And it requires as I understand it only the choice of one HMO, not a second.

Mr. CARPENTER. That is correct. One of each qualified type, either a group practice or an independent practice association that might be in the same area.

Chairman JACOBS. Basically, as I understand the Federal statute, the choice would be between essentially two plans, insofar as Federal law is concerned.

Mr. CARPENTER. Yes; that is correct.

Chairman JACOBS. The Chair expresses the gratitude of the committee for the panel's participation and contribution to the record.

Our next witness from the American Academy of Actuaries is W. H. Odell, if you will come forward, and the witness after Mr. Odell is Boyd Thompson. Mr. Thompson, if you will get close up here to follow on, we will save a little walking time between witnesses.

The Chair will announce the following witness along with the current witness each time.

STATEMENT OF W. H. ODELL, CHAIRMAN, COMMITTEE ON HEALTH INSURANCE, AMERICAN ACADEMY OF ACTUARIES, ACCOMPANIED BY HARRY L. SUTTON AND JOHN COOKSON

Mr. ODELL. Mr. Chairman and distinguished members of the subcommittee, my name is W. H. Odell. I am the chairman of the Committee on Health Insurance of the American Academy of Actuaries.

The American Academy of Actuaries is a professional organization composed of actuaries practicing in a variety of fields, including the area of health insurance.

Today we will limit our discussions to a few issues. First, the impact of cost-sharing on the cost of health care.

Actuaries have generally found cost-sharing, deductibles, co-payments or other patient payments will reduce the use of most types health services significantly. By making patients more aware of the cost, fewer services will be demanded, and more attention paid to price increases by employers. These in turn would reduce inflationary pressures.

Concerning possible variations of the financial impact of a tax cap on tax-free employer contributions to health plans. Such cap would have to be carefully constructed or it will have a widely different financial impact on employees in different situations.

For example, a flat cap in all cases will have relatively heavier financial consequences for employees in firms in high-cost areas, small firms, and firms with an older work force.

Third, the effect of mandating multiple choices. Just as with the employer contribution cap, the rates and, therefore, rebates, may have to be allowed to vary by geographic location and actuarial category.

Also, what is the exact definition of the premium rates which are to be compared to determine the amount of refund?

But the most serious problem is adverse selection. Adverse selection refers to the tendency of younger and healthier employees to choose a low option and for older or less-healthy employees to choose the high option.

The cost of the options depend more on the age and health of those choosing them than on the difference in cost-sharing. Thus, the savings when younger and healthier employees change from the high- to the low-option plan is less than the difference in option costs.

Employer outlays will thereby be increased if the full difference in premium rates is paid as a rebate. The principle beneficiaries will be the younger and healthier employees.

These matters are gone into in more detail in our booklet which is included with our testimony, "Risk Classification: Statement of Principles."

Fourth, who pays for those in poor health in a multiple-choice system? In the current health care financing system, the employer pays a relatively greater share of the cost of the less healthy than of the healthy employees.

However, under the proposed legislation, this cost would be borne either by the employer or by the high-cost employees themselves.

Fifth, the effect of requiring a choice of three insurers on the cost of employer health plans. Requiring more than one insurer is intended to introduce competition among insurance providers and thereby cut down costs of coverage.

However, the results may be just the opposite.

As you can see with respect to each of these points, our concern is that the proposed legislation may have the opposite effect of what is intended.

Turning to a different issue, many actuaries are concerned about the basis of financial reporting of the liabilities of uninsured plans.

State insurance regulatory authorities are presently considering making the financial reporting requirements of such plans more exacting but definitive guidance is presently lacking.

Also, we believe that insufficient attention has been given to the question of whether the contribution levels of these plans are sufficient to provide the benefits anticipated by plan members.

The proposed Gephardt legislation provides for preparation or review of financial statements by experts and also review of the sufficiency of contribution levels. The actuarial profession commends such proposals and stands willing to assist you in this regard.

We hope these observations, which are elaborated on in our written testimony, which we ask be included in the record, will be of use to you in your deliberation on these important bills.

We will be glad to assist you with the actuarial considerations inherent in the procompetition proposals. Thank you for this opportunity to testify.

[The prepared statement follows:]

STATEMENT OF W. H. ODELL, CHAIRMAN, COMMITTEE ON HEALTH INSURANCE OF THE AMERICAN ACADEMY OF ACTUARIES

Mr. Chairman and distinguished members of the Subcommittee, my name is W. H. Odell. I am the Chairman of the Committee on Health Insurance of the American Academy of Actuaries. On behalf of the Academy, I wish to thank you for the opportunity to appear before you today to discuss some of the issues involved in the "pro-competition" health care bills.

The American Academy of Actuaries is a professional organization composed of actuaries practicing in a variety of fields, including the area of health insurance. Since I am representing an organization composed of individuals who hold diverse political views, this statement will not generally favor or oppose specific legislative proposals. Instead, I will discuss the financial implications of some of the proposals to assist you in your deliberations. Attached to this statement is additional background information about the American Academy of Actuaries.

As this hearing is likely to be the first of many in Congress' search for a way to achieve a marketplace environment for health care prepayment programs, we would like to offer our assistance in studying the probable effects of specified sections of some of the "pro-competition" bills—especially those that might produce unwanted and unexpected results.

The "pro-competition" bills have raised a number of technical issues which are of interest to health actuaries. The most important technical issues are: The impact of greater cost-sharing on the cost of health care; possible variations in the financial impact of a uniform limit on tax-free employer contributions to health plans; the effect of mandating multiple choices; who pays for those in poor health in a multiple choice system; and the effect of requiring a choice of three insurers on the cost of employer health plans.

1. THE IMPACT OF GREATER COST-SHARING ON THE COST OF HEALTH CARE

Actuaries have generally found that cost-sharing, i.e., deductibles, copayments, or other patient payments, will reduce the use of most types of health services significantly. By making patients more aware of the cost, fewer services will be demanded and more attention will be paid to price increases by providers. These in turn would reduce inflationary pressures.

2. POSSIBLE VARIATIONS IN THE FINANCIAL IMPACT OF A UNIFORM LIMIT ON TAX-FREE EMPLOYER CONTRIBUTIONS TO HEALTH PLANS

One possible measure to discourage growth in first-dollar coverages is to place what is commonly called a "tax cap" on the employer contribution. A similar cap already exists on employer paid group life insurance over $50,000. Such a cap would have to be carefully constructed or it will have a widely different financial impact on employees in different situations. For example, a flat cap in all cases would have relatively heavier financial consequences for employees of: Firms in high cost areas ($125 a month buys much more coverage in South Carolina than it does in New York leaving relatively more for the New York employee to pay); small firms, who pay more for the same coverage as a result of higher administrative expenses; and firms with an older work force.

Therefore, any cap considered should include variation by geographic location, size of firm, and actuarial category (e.g., age, sex) if such variations in financial impact are to be avoided. Some of the proposed legislation does vary a cap by certain of these factors, while other proposals do not provide for such variance.

3. THE EFFECT OF MANDATING MULTIPLE CHOICES

Some proposals would require an employer to offer two (or more) plans, providing a choice of "high" option coverage and "low" option coverage. Employers would be required to pay the same contribution per employee to each plan. Payment would be in the form of rebates to those choosing the "low" option.

Multiple option requirements create numerous problems. First, there are complex technical problems with defining "equal" contributions. The premium paid monthly by the employer may differ from the actual cost of insurance for enrollees in each option for several reasons. Insurers may pay dividends, make more profit or loss on one option than the other, or vary rates for many other factors.

Further, as with the employer contribution cap, the rates, and therefore the rebates, may have to be allowed to vary by geographic location and actuarial category. Some of the proposed legislation provides for such variance while other proposals do not.

The most serious problem, however, is "adverse selection." Adverse selection refers to the tendency for younger and healthier employees to choose the "low" option, and for older or less healthy employees to choose the "high" option. The premium rates of the options depend more on the age and health of those choosing them than on the difference in cost-sharing. Thus, the savings when younger and healthier employees change from the "high" to "low" option plan is less than the difference in premium rates. Employer outlays will thereby be increased if the full difference in premium rates is paid as a rebate. The principal beneficiaries will be the young and healthy employees.

Our major concern with many of the "pro-competition" bills as they now appear has to do with adverse selection. We are concerned that providing "high" vs. "low" option coverages to employees could result in a significant increase in adverse selection. If this should happen, then instead of achieving the desired result of competitive forces, that is selection of the most efficient health care delivery systems, the more probable result could be higher employer payments.

It is not our intent to imply that competition in a private enterprise system cannot be applicable to the health care sector. Our concern is that the competition will occur in attempting to enroll the healthiest employees rather than the hoped-for competition between health care delivery systems.

For competition to occur between providers of health care services, i.e., the physicians and hospitals, they must feel the financial effects of the competition between health care delivery systems. Under the proposed legislation, this will not be the case, and providers of health care services will have little or no incentive to achieve greater efficiency in the delivery of health care services.

The concept of adverse selection is discussed more fully in a booklet published by the American Academy of Actuaries entitled "Risk Classification: Statement of Principles." This booklet is attached to our testimony.

4. WHO PAYS FOR THOSE IN POOR HEALTH IN A MULTIPLE CHOICE SYSTEM

In the current health care financing system, the employer pays a relatively greater share of the cost of the less healthy than of healthier employee. This occurs because a group premium rate is actually a composite of the different rates applicable to each family in the group, both healthier and less healthy. The employer customarily contributes a larger portion of the premium and the employee makes a flat contribution for just the remaining portion of the premium. This is therefore an attractive purchase for all members of the group.

Proposals which mandate multiple choice for employment-based insurance would, in their current form, prevent this cross-subsidization. It is likely that if two options were required, the healthier employees would be more likely to choose the low option, anticipating lower utilization of health services, thereby leaving the less healthy employees in the high option, and driving up its cost.

The situation is like the experience of the so-called assessment societies which for a time flourished in the early 1900's. These assessment societies offered life insurance benefits to members without making price distinctions for different age groups. Many younger members were gradually attracted to other lower price plans that offered reduced rates for younger enrollees. This opting-out resulted in higher prices for the remaining older insured members. Some of those remaining members then opted out because of the higher prices. An upward spiral of higher prices resulted for the fewer and fewer remaining older lives. Consequently, these assessment plans became economically unsound and were unable to survive in the competitive market place.

Pro-competition health legislation might create a situation similar to that of the assessment societies of 75 years ago. Further aggravating this danger would be the rebate of the full difference in cost of a multiple choice plan. It over-compensates the younger, healthier, or lower utilizers for electing the low cost of the high option plan, producing the same spiral effect as did the aforementioned life insurance assessment plans.

5. THE EFFECT OF REQUIRING A CHOICE OF THREE INSURERS ON THE COST OF EMPLOYER HEALTH PLANS

Requiring more than one insurer is intended to introduce competition among insurance providers and thereby hold down costs of coverage. However, the results may be just the opposite. If several insurers are covering one group of employees, there will be fixed administrative costs and sales associated with each. These will in the aggregate be greater than if there were only one insurer.

Under a three carrier rule, there are two competitions, one to be one of the carriers and another to enroll employees. Competitive forces will encourage insurers to enroll the healthiest employees. Since the main financial rewards will go to the carrier that enrolls the healthiest employees, insurers will design their plans to appeal to them. This may reduce the variety of coverage available as each insurer attempts to appeal most to the young and healthy. This effect is far afield from the original intent of the three carrier rule.

Since the insurer cannot be certain that other carriers will not enroll the healthiest employees leaving only the less healthy enrolled in its plan, the insurer may tend to raise rates to cover this additional uncertainty about the composition of its segment of employees. This would further increase the cost of insurance.

Finally, on a somewhat different issue, many actuaries are concerned about the basis of the financial reporting of the liabilities of uninsured plans. State insurance regulatory authorities are presently considering making the financial reporting requirements of such plans more exacting. But definitive guidance is presently lacking. Also, we believe that insufficient attention has been given to the question of whether the contribution levels of these plans are sufficient to provide the benefits anticipated by the plan members. Some of the proposed legislation provides for preparation or review of financial statements by experts and also for a review of the sufficiency of contribution levels. The actuarial profession commends such proposals and stands willing to assist you in this regard.

We hope these observations will be of use to you in your deliberations on these important bills. We will be glad to assist you with the actuarial considerations inherent in the "pro-competition" proposals. Thank you for this opportunity to testify.

APPENDIX A

The American Academy of Actuaries is a professional organization of actuaries which was formed in 1965 to bring together into one organization all qualified actuaries in the United States and to seek accreditation and greater public recognition for the profession. It includes members of three founding organizations—the Casualty Actuarial Society, the Conference of Actuaries in Public Practice, and the Society of Actuaries.

Requirements to become a member of the Academy can be summarized under two broad headings: (1) education and (2) experience. At the present time, the education requirements for membership can be satisfied by passing certain professional examinations given either by the Casualty Actuarial Society or the Society of Actuaries or by becoming an "enrolled actuary" under the Employee Retirement Income Security Act of 1974 (ERISA). The experience requirement consists of three years of responsible actuarial work.

As of the end of 1980, the Academy membership exceeded 6,200. The Academy is unique as the national actuarial organization for actuaries in all areas of specialization. These actuaries have a variety of types of employment, including insurance organizations, consulting firms, academic institutions, and government. A large majority of those individuals who have satisfied the education and experience requirements of the Academy have, in fact, joined the Academy.

The Academy is active in the development of guides to professional conduct and standards of practice required of members in their professional practice. The Academy is also active in government relations, liaison with other professions and public relations.

Chairman **Jacobs**. Thank you, sir.

Mr. Gephardt.

Mr. **Gephardt**. I have no questions. I deeply appreciate you coming here and making this testimony. It's been very helpful.

Chairman **Jacobs**. Mr. Duncan.

Mr. **Duncan**. I have no questions. I do thank you.

Chairman **Jacobs**. The Chair expresses gratitude of the committee, especially for the technical testimony you have given, sir.

It will be in the record, along with your oral statement.

Mr. Thompson of the American Association of Foundations for Medical Care.

STATEMENT OF BOYD THOMPSON, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE, ACCOMPANIED BY WILLIAM D. FULLERTON, WASHINGTON TECHNICAL CONSULTANT

Mr. **Thompson**. Thank you, Mr. Chairman. I have with me Bill Fullerton, our Washington technical consultant.

Let me summarize our testimony submitted to you. We are a national association of independent practice social-type HMO's and foundations for medical care with 102 members, 25,000 physician members and approximately 1½ million people as subscribers.

AAFMC has supported the concept of consumer choice of health insurance to advance competition in health care for 4 years and continues that support.

The present situation is that there are many variations of anticompetition and overregulation in the system, many created by the Federal Government.

All of the bills make substantial gains in the right direction. AAFMC believes that it is the individual consumer choice of plan will be the key to the success of these proposals.

Our members have faced competition and continue to face competition every day, and they do so successfully. We are prepared to solve those problems.

We count among our members 70 health maintenance organizations sponsored and associated with individual practice associations, IPA's. The growth of IPA/HMO's is expected to accelerate.

They are expected to grow primarily because of the growing surplus of physicians and because of our attractiveness to national firms moving into the health care delivery market.

In addition to the IPA/HMO's, we have the oldline foundations for medical care. These were the prototypes of IPA's. All the member plans see the effects of the lack of organizational competition and must continuously be on guard against the effects of anticompetitive forces and somehow come to grips with them.

As one example, some member organizations have reported that employee counselors in some companies tend to advise employees with serious existing health problems in the family to enroll in our plans, rather than some other plan "because they give good service and you will not have to pay any bills."

We do not mind accepting patients like that, except that if we have to have many more than our share, we find it difficult to compete on the price of coverage with plans that select the better risks.

This is an example of the competition which often goes on among insurers today.

It is competition to enroll the best risk which, in turn, lower premium costs which, in turn, market their plans. It is not competition based on lower premium costs achieved by more cost-effective health care delivery.

Even this administration with its dedication for fair competition, can fall into supporting or creating policies that do not stimulate competition for survival of the most efficient, but rather, survival of the plan with the healthiest enrollees.

Yet, our member organizations not only compete favorably despite many existing obstacles to open and fair competition, but also are dedicated to the delivery of high-quality care, as well as cost-effective care.

This dedication derives from the fact that our members are so closely associated with practicing physicians in their communities. They learned long ago that a sound utilization review control element must be built into their plans to assure both the quality of health care delivered to subscriber families and cost-effectiveness of that care.

While we support the basic thrust of procompetition bills, our members have not as yet studied all of the ones introduced in previous years in full detail.

We do not plan to try to reach our specific conclusions until the administration bill and other updated proposals expected to be introduced have been made available for study.

There are critical issues in all these bills which need to be worked out carefully, and we know the sponsors are aware of many of them and are continuing to work on them.

Such issue as how to finance medical education under a competitive system. How to maximize consumer knowledge of available choices, information about access and quality, as well as price.

How to assure that plans will compete on their ability to contain cost and assure quality rather than on their ability as now to enroll the better risks.

How to deal with geographic variations in health costs and how to assure that both short- and long-term costs to government, private industry, and patients, will be reasonable or among a set of issues that are both troublesome and necessary to solve.

However, we believe these problems can be solved. We will work to help solve them, because we believe so firmly in the overall goal.

We do have another concern which may be worth some discussion here. In all of the proposals made so far, there is a strong role for the Federal bureaucracy in setting and enforcing the rules of the competition under which we will all play.

While the extent of that rule for the bureaucracy can be argued and we hope it will be kept within reasonable bounds, in the end, there will still be a substantial refereeing role to be performed.

We would urge the Congress to consider very carefully whether the administrative arrangement at the Federal level to carry out these refereeing functions should be assigned to an existing department, given the need for a considerable body of expertise in the private health insurance and the need for the administrating agency to be scrupulously and obviously fair.

I know that at least one bill depends heavily on the court system to meet these needs, but we have some question whether it is the best answer.

In fact, some might call this concept the lawyer's relief provision.

However the Congress may resolve these issues, we want you to know that we are anxious and willing to make the considerable expertise of our members available to your committee and to others who are interested in moving that competition effort forward.

Thank you very much for your attention. I would be glad to answer any questions members of the subcommittee may have.

[The prepared statement follows:]

STATEMENT OF BOYD THOMPSON, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF FOUNDATIONS FOR MEDICAL CARE

SUMMARY OF TESTIMONY

1. AAFMC is the national association of Independent Practice Association type Health Maintenance Organizations and Foundations for Medical Care with 102 members, 25,000 physician members and 1.5 million people as subscribers.
2. AAFMC has supported the concept of consumer choice of health insurance to advance competition in health care for 4 years and continues that support.
3. Present situation is that there are many varieties of anti-competition and overregulation in the system, many of them created by the federal government.
4. All of the bills make substantial gains in the right direction. AAFMC believes that it is individual consumer choice of plan which will be the key to success of the effort. All the proposals have problems which will need to be solved. AAFMC offers the experience of its members in solving the problems.

STATEMENT

Mr. Chairman, my name is Boyd Thompson, and I am the Executive Vice President of the American Association of Foundations for Medical Care (AAFMC).

AAFMC represents 102 physician-sponsored organizations active in the delivery and financing of health care services to groups of subscribers. Our member organizations count 25,000 physicians as individual members, and they provide health care to about a million and a half Americans. All of these members continue to increase as our membership continues to grow.

As an association whose members are involved in health care delivery systems which have been competing with traditional approaches as well as with other HMOs for many years—some for more than a quarter of a century—we are very pleased to present our views on the important subject of improving effectiveness of health care delivery through the introduction of additional competitive forces and the removal of anticompetitive rules and regulations. We recognize that there has traditionally been competition within the health care industry. Among physicians there is competition by specialty, by access and availability to patients and by price.

We support very strongly the efforts of those in Congress and in the Administration to substitute strengthened forces of the marketplace for regulation—often now used in a vain effort to induce more cost-effective behavior on the part of health care insurers and care providers. The House of Delegates of our organization formally adopted a position more than three years ago to support the consumer choice principles advanced by Alain Enthoven and others. We found those principles consistent with the objectives of our organization and consistent with the practices our members have found to be necessary for successful operation in the health services marketplace. We believe that individual choice of health insurance plan is the key to making these proposals work effectively.

Our members face competiton every day—and they do it successfully. We count among our members 70 Health Maintenance Organizations sponsored or associated with Individual Practice Associations (IPA).

For those members who may not know what an IPA/HMO is, let me briefly describe a typical plan.

An IPA is a group of physicians, each practicing in his or her own office or clinic, who organize to sponsor a prepaid health plan. The plan is in one sense a health insurer that competes in the market with Blue Cross/Blue Shield and other insuring organizations operating in its locality. The plan is at risk just as are other insurers. An important difference between IPAs and traditional insurers however, is that patients do not need to keep records and fill out claims forms; they merely show their cards, at the physician's office or the hospital, and the plan makes reimbursement directly.

Unlike some prepaid group health plans, those who subscribe under this arrangement can almost always retain their current physicians. And, the availability of physicians throughout the area assures easy access to care—long drives to centralized facilities are not necessary.

The plans are cost-effective because the physicians who belong are likely to share in the risk to some extent and, more importantly, they agree to have their work reviewed by their peers in the plan and to accept the conclusions of these peers on reimbursement and medical necessity decisions. In this sense an IPA is a health care delivery system competing against physicians practicing in other ways.

Almost all of our members put physicians at risk for physicians' services. This means that if plan costs for physicians' services exceed estimates, reductions in payments to physicians are imposed to keep total costs under control. In addition, more than 80 percent of our plans also put the physicians at some risk for plan payments for hospital services. The combination of internal quality and utilization control systems and the risk factor results in our plans using substantially lower inpatient hospital days per thousand enrollees than is the case for more traditional forms of health insurance.

The growth in the formation of IPA/HMOs is expected to accelerate. Paul Ellwood of InterStudy expects private investment in IPA/HMOs to grow primarily because of the growing surplus of physicians and their attractiveness to national firms moving into the health care delivery market.

In addition to IPA type HMOs, we have what I call the old-line Foundations for Medical Care in our Association.

Foundations for Medical Care (FMCs) were the prototype for IPAs.

An FMC is an organization of physicians formed for the purpose of assessing quality medical care for the people of a given area at a reasonable cost to employers and insureds. They sponsor programs that provide comprehensive benefits coupled with extensive peer review programs that guarantee proper use of medical facilities and services.

All of our member plans see the effects of the lack of organizational competition and must continuously be on guard against the effects of anticompetitive forces and somehow come to terms with them. As one example, some of our member organizations have reported that employee counselors in some companies tend to advise employees with serious existing health problems in the family to enroll in our plans rather than some other plan "because they give good service and you will not have to pay any bills." We do not mind accepting patients like that except that if we have many more than our share, we find it difficult to compete on the price of the coverage with plans that select the better risks. This is an example of the competition which often goes on among insurers today—it is competition to enroll the best risks which, in turn, lower premium costs which help to market their plans. It is not competition based on lower premium costs achieved by more cost-effective health care delivery. And, even this Administration with its dedication for fair competition can fall into supporting or creating policies that do not stimulate competition for survival of the most efficient, but rather survival of the plan with the healthiest enrollees. In its desire to restrain the costs of health insurance for federal employees, the government this year permitted—even encouraged—the major insurers to increase cost-sharing provisions such as deductibles and co-insurance yet will not permit our members who participate in the program to do the same. Clearly, we are placed in a poor competitive position because of such government action.

Yet, our member organizations not only compete favorably despite many existing obstacles to open and fair competition, but also are dedicated to the delivery of high quality care as well as cost-effective care. This dedication derives from the fact that our members are so closely associated with practicing physicians in their communities. They learned long ago that a sound utilization review control element must be built into their plans to assure both the quality of the health care delivered to subscriber families and the cost-effectiveness of that care.

Among the points you will hear, if you have not already heard it, is that too much emphasis on cost-effectiveness and competition can lead to the withholding of necessary care. That may very well be a risk under some plans, but I can tell you that our members have solved that problem. While the individual physician member of an IPA type HMO is at some financial risk if the costs of the plan exceed estimates, his share of the risk is modest enough that an effective incentive for withholding of needed care simply does not exist. Moreover, the plan's internal quality control mechanisms continuously monitor care to assure that neither over nor under utilization of care becomes a problem. The plan understands that it is competing not only on the price of its product but also on the quality of its care and the manner in which the care is delivered.

While we support the basic thrust of the pro-competition bills, our members have not, as yet, studied all of the ones introduced in previous years in full detail. We do not plan to try to reach our specific conclusions until the Administration bill and other updated proposals expected to be introduced have been made available for study. There are critical issues in all of these bills which will need to be worked out carefully, and we know that the sponsors are aware of many of them and are continuing to work on them.

Such issues as how to finance medical education under a competitive system, how to maximize consumer knowledge of available choices, information about access and quality as well as price, how to assure that plans will compete on their ability to contain costs and assure quality rather than on their ability as now, to enroll the better risks, how to deal with geographic variation in health costs, and how to assure that both short and long term costs to government, private industry and patients will be reasonable, are among a set of issues which are both troublesome and necessary to solve. However, we believe these problems can be solved. We will work to help solve them because we believe so firmly in the overall goal.

We do have another concern which may be worth some discussion here. In all of the proposals made so far there is a strong role for the federal bureaucracy in setting and enforcing the rules of the competition game under which we will all play. While the extent of that role for the bureaucracy can be argued—and we hope it will be kept within reasonable bounds—in the end there will still be a substantial refereeing role to be performed. We would urge the Congress to consider very carefully whether the administrative arrangement at the federal level to carry out these refereeing functions should be assigned to an existing department given the need for a considerable body of expertise in private health insurance and the need for the administering agency to be scrupulously and obviously fair. I know that at least one bill depends heavily on the court system to meet these needs, but we have some question whether that is the best answer.

However the Congress may resolve these issues, we want you to know we are anxious and willing to make the considerable expertise of our members available to your committee and to others who are interested in moving the competition effort forward.

Thank you very much for your attention. I will be glad to answer any questions members of the subcommittee may have.

Chairman JACOBS. Mr. Thompson, we thank you for your testimony. I believe there are no questions at this time. Your statement will be part of the record.

The Chair will announce that Congressman Guarini requests Dr. Di Paolo meet Mr. Guarini in his office, 1530 in this building. Take the elevator to five.

The Chair will have to declare a short recess, probably no longer than 2 minutes, because of the vote on the floor, and request that Mr. Pitts come forward to the witness table.

We shall resume shortly. Is Mr. Pitts present?

STATEMENT OF TERRANCE PITTS, CHAIRMAN, HEALTH AND EDUCATION STEERING COMMITTEE, NATIONAL ASSOCIATION OF COUNTIES (SUPERVISOR, MILWAUKEE, WIS.), ACCOMPANIED BY JANET SMITH, LEGISLATIVE REPRESENTATIVE

Mr. PITTS. Yes, sir.

Chairman JACOBS. If you will come forward, probably Mr. Rangel should arrive any minute and we will resume the testimony then.

For the record, this is Mr. Terrance Pitts, chairman of the Health and Education Steering Committee of the National Association of Counties.

Mr. Pitts is a supervisor of Milwaukee, Wis.

Mr. PITTS. That's correct, Mr. Chairman.

Chairman JACOBS. Just stand down until Mr. Rangel arrives. [Recess.]

Mr. RANGEL [presiding]. Mr. Pitts, thank you again. You were about to begin your testimony.

If the chairman didn't welcome you, I do for the National Association of Counties.

Mr. PITTS. Thank you, Mr. Chairman.

I am Terrance Pitts, chairman of the Health and Education Steering Committee of the National Association of Counties, and a member of the board of supervisors of Milwaukee County, Wis. And I am chairman of its health committee.

Along with me today is Janet Smith of the National Association of Counties and she is our lobbyist for health.

On behalf of the National Association of Counties, I want to thank you for the opportunity to testify on various proposals to stimulate competition in health care financing.

Mr. Chairman, we would also like to commend you for holding this series of hearings at this time. These are extremely important proposals, which deserve full and complete consideration. We know there has been a tremendous amount of skepticism expressed about the general concept of competition. Hopefully, this hearing will help clear the air and serve to refocus the nature of the debate. Up until now, it seems to us much of the discussion has been based on misperception, and the desire to maintain the status quo.

However, we at the county level are here today to say that we cannot afford the status quo. The crisis in public health care financing is mounting at a very alarming rate, and we see the access of the poor to essential health care services diminishing before our very eyes.

I have the summary of the 1982 proposed budget in Milwaukee County for 1982. I would like to quote our county executive:

> I am forced to recommend a 1982 budget that will force cutbacks in many country programs, including closing of county facilities such as the Children's Home, Child and Adolescent Treatment Center, Nursing Home, County School of Nursing and Downtown Medical Health Services Clinic.

In addition to that, he is recommending the transferring of the medical complex, which is our hospital, to a private corporation.

The changes mentioned above and many other changes summarized within this document have led to a substantial decrease in the county's 1982 expenditure budget.

During 1982, that budget will total $412 million, a decrease of $78 million from the amount required this year.

Unfortunately, as a result of the State and Federal revenue cutbacks which I mentioned earlier, the amount of property tax funding required next year will total $122 million, an amount equal to the county State-imposed tax levy limitation.

Last year, our tax levy was 90, approximately $90 million. With even the increase from $90 million to $122 million, we are forced to close all of these institutions.

We can only hope that this subcommittee will take action in the ensuing months which addresses these critical concerns.

Mr. Chairman, I am sure our concerns are not unfamiliar to you, but very briefly, I would like to outline them for the record.

Last year, according to data compiled by the Advisory Commission on Intergovernmental Relations [ACIR], counties and other local governments spent some $13 billion in local tax dollars on health care.

Mr. Chairman, and members of the subcommittee, you may recall that this was the approximate price tag of some proposals for national health insurance a couple of years ago. In fact, counties are the mainstay of our health care system in lieu of comprehensive coverage. We provide and finance health care services for tens of millions of elderly, poor, disabled and indigent Americans, through our county hospitals, nursing homes, clinics, home health programs and other health and mental health facilities.

Given the continuing skyrocketing cost increases, and given current cutbacks in Federal medicaid, medicare and other health programs, you can well imagine our concerns. At this point, we feel we are moving backward, not forward, in terms of national health care policy. Hopefully, new changes in medicaid giving greater flexibility to States and counties in program implementation will help offset some of those funding cutbacks and actually improve service delivery.

At the same time, we are seeing an increasing tendency to deregulate health care, paralleling other deregulation efforts. In the past, competition "purists" contended that this was a necessary step, in order to reform the health care marketplace.

Now, increasingly some of those purists seem to be moderating their views, if not publicly, at least in private, acknowledging the need for balance between regulation and deregulation. We would certainly concur. We are opposed to the wholesale elimination of planning, certificate of need and medical review activites, and favor a system of reasonable controls on the allocation and distribution of our health care resources. We do not believe competition alone will automatically produce an appropriate array and amount of services in all geographic areas for all population groups. Moreover, we believe that if existing controls are removed in the near future, the rise in health costs will surely accelerate. That rise will almost certainly be translated into further cuts in Federal spending under medicaid and medicare. We have only to look at the increase in hospital costs since the defeat of the hospital cost containment bill to see what impact voluntary cost containment efforts actually have on rising costs, and what the consequences are for the public sector, including county governments.

We find these trends very alarming—Federal funding cuts for health care, occurring concurrently with deregulation, while health care costs continue to escalate.

How do we constructively relate these concerns to the proposals currently under consideration? As I indicated earlier, these proposals contain a number of provisions which address needs for public sector reform.

Specifically, we believe the following types of provisions should be incorporated in the development of a final proposal for subcommittee action:

Provisions enabling counties to participate in pooling arrangements with other entities, for the development of prepaid health plans. Congressman Gephardt's bill, H.R. 850, currently addresses this need by permitting many types of entities, including local governments, to develop qualified health plans. Counties need a mechanism which enables them to limit their health care liabilities through prepaid systems. We would hope that this concept can be addressed in the near-term, perhaps by providing for demonstration sites where various local pooling arrangements can be tested.

Provisions assuring the development and establishment of a system for prospective budgeting under medicare, such as contained in H.R. 850. It seems clear that this is an approach which has significant cost savings potential, without adversely affecting access to and quality of care.

Provisions assuring coverage for bad risks. Without such assurances, those individuals will in large measure be dependent upon county facilities for their care.

Provisions for coverage of catastrophic and preventive health care costs. We are particularly pleased to see in Senator Hatch's bill the attention to preventive care, which has for too long been ignored as an area for reform.

Provisions providing for moderate cost-sharing, as a means of establishing cost-conscious behavior on the part of consumers. We would prefer to see that type of provision applied only to elective types of care, however.

In summary, we strongly urge that a proposal be developed for health care reform, which includes provisions encouraging cost consciousness on the part of consumers and providers, and which also holds the promise of improved quality and access to care. We also strongly urge you to move ahead on such a proposal, for passage in the coming year, and welcome the opportunity to comment on the specifics, as the subcommittee proceeds with its work.

You will note that we are not advocating provisions which would significantly increase Federal spending, and are instead calling for a restructuring of existing resources. We cannot afford to do less.

Thank you, Mr. Chairman.

Mr. RANGEL. No questions. Thank you for your testimony.

Chairman JACOBS. I have read your testimony, sir. We appreciate its contribution to the record.

I might just ask one question. Do you suppose there would be anything to be gained in terms of cost control to the Federal Government under the medicare program, perhaps for the medicaid program, as well, if the U.S. Government accepted the guidelines of the National Hospital Association for increases in medical, or rather, hospital costs, from year to year. That is, the Government simply made it a matter of law that it would not do business with any hospital that ran afoul of those guidelines?

For example, say there were nine hospitals in a metropolitan area, eight stayed within the guidelines, one went substantially beyond the guidelines. For the hospital that exceeded the guidelines, HCFA would deem the contract with the Government for medicare reimbursement broken by that circumstance.

Do you think there is any merit in that?

Mr. PITTS. That question we would like to take into consideration, under consideration with the committee. At first blush, my answer to the question is in the affirmative.

However, we don't know the impact of shifting of that cost to the local level and to the public sector and to the consumer, per se.

Chairman **Jacobs**. As one member of the committee, I would be grateful if your organization might subsequently submit some sort of response, a studied response.

As you say, it is first blush, right now, but for the record, we would welcome a studied response.

Mr. **Pitts**. We will do that, Mr. Chairman, thank you very much.

[The following was subsequently received:]

National Association of Counties,
Washington, D.C., October 27, 1981.

Hon. Andrew Jacobs,
Chairman, Subcommittee on Health,
House of Representatives, Washington, D.C.

Dear Congressman Jacobs: This is in response to your request of October 2nd for our organization's views on the use of AHA guidelines as a technique for hospital cost containment.

As we understand it, the American Hospital Association currently has no guidelines which they are using as a target for controlling hospital cost increases. Thus, it is difficult to speculate to what degree such an approach would reduce spending below the current annual rate of twenty percent.

In the past, we supported measures for hospital cost containment which were designed to take into account a wide range of institutional and geographic differences. We have also favored an approach which addressed all third party payors, rather than just one or two payors. We would be opposed to any arbitrary approach to cost containment—whether it be in the form of a Medicaid cap or a rigid system of controls—because of the massive cost-shifting which would be likely to occur to public hospitals. We do, however, support the implementation of prospective reimbursement under Medicare and Medicaid.

In addition, our organization supported the elimination of freedom of choice requirements under Medicaid, where it did not have a detrimental effect on access to, or quality of, care. Our Health and Education Steering Committee urges that the implementation of this provision be monitored in the months ahead, to see whether that approach might be applied to Medicare as well.

We appreciate the opportunity to respond to your inquiry. Please feel free to contact us at any time.

Sincerely,

Janet Smith,
Legislative Representative.

Chairman **Jacobs**. Thank you very much for your contribution.

The next organization to be represented is the Health Industry Manufacturers Association, Mr. Harold O. Buzzell, president.

STATEMENT OF HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION, ACCOMPANIED BY WAYNE I. ROE, DIRECTOR, RESEARCH AND ECONOMIC STUDIES

Mr. **Buzzell**. Thank you, Mr. Chairman.

Chairman **Jacobs**. Following this testimony, the next panel will include Mr. Frederick and Mr. Collins.

Mr. **Buzzell**. Mr. Chairman, I am aware of your time constraints. I will be brief.

I am Harold Buzzell of the Health Industry Manufacturers Association, an organization that represents 265 manufacturers of medical products. We appreciate the opportunity to testify.

I want to start by saying that we support the notion of competition. First, as employers, we pay 90 percent of the health insurance bill for our workers, and our workers number in the millions.

And we are distressed that health insurance premiums in 1981 will probably rise over 20 percent.

Second, these rapidly rising health care costs, in our judgment, will lead to Government action. You have heard testimony this week that hospital expenditures in 1981 will also climb about 20 percent.

This clearly poses a problem for the Federal Government, with your programs such as medicare, just as it does for us as employers in the private sector.

As an industry built on the discipline of free enterprise, we clearly support any concept which is based on competition, as opposed to a regulatory approach.

And third, it is quite clear that a major change is needed in the current system. First-dollar insurance and cost-based reimbursement cause consumers and providers to ignore costs. Competition proposals are based on the principles of financial incentives for consumers to consider options.

Clearly, in my judgment, this requires significant change. It requires changes in tax laws, it requires removal of certain health regulations and it requires a restructuring of the medicare program. I believe these things can be done without compromising the quality of the care.

I might add that any competitive proposal has potential to reduce health insurance. And that quite clearly will lead to a reduction in the number of products that our manufacturers will be able to offer in this marketplace. Nevertheless, we support competition as being in the best long-term interest of both our companies and this country.

As both suppliers of health care products and as employers, I believe we are in a position to evaluate potential effects of competition in both the marketplace and the workplace.

I would like to discuss today how competition would affect my members as employers, as opposed to my members as people who make products.

I call the subcommittee's attention, if I may, to the data contained in three tables. By using these tables, I would like to quickly summarize the multi-industry data that is contained in a major report that we just completed and which we will make available to this subcommittee.

The first table shows that about 30 million Americans are covered by employer-based group family health insurance and that employers are the major contributors. That is, for example, employers pay over $100 per employee for one-third of this group.

So we have about 10 million workers in this country that are in family plans and have an employer that pays a hundred dollars or more for their coverage.

Now, although not shown on the chart, but pointed out in our detailed statement, we note that employers pay over 80 percent of their workers' premiums.

Since employer contributions are tax free, they represent a substantial subsidy. For example, about 2 million workers receive over $150 and 1½ million, as shown by the chart, receive over $200 in tax-free health benefits each month.

Tax-free health premiums, in our judgment, clearly lead to excessive coverage.

The second table shows what would happen if these subsidies were capped. For example, a $125 limit, which Senator Durenberger has proposed, would affect about 6.5 million workers, or 20 percent of this universe.

That is, if contribution rates stayed the same, these workers would pay an average monthly tax of about $18 to maintain their coverage.

These payments would total nearly $1.5 billion annually. Furthermore, any additional insurance purchased by these workers would be purchased with after-tax dollars, thus encouraging greater cost consciousness, in our judgment.

The final table speaks to the issue of alternatives for cost-conscious workers who want to reevaluate their coverage.

In our own industry, we know that few workers have an alternative to a single-employer-based plan. As a consequence, the basis for this table is an assumption that many workers would prefer a less expensive plan if rebates were available.

Further, these rebates could be substantial enough to be attractive while still providing adequate coverage, and to illustrate, the table shows that a low-option family plan costing about $35 per month would make over 50 percent of this population eligible for a $52 rebate.

In our judgment, many workers would find a rebate of this amount attractive. For individual enrollees, the average rebate would be about $21 a month.

Now, the detailed study that I made reference to before provides persuasive evidence that competition concepts would have a sizable—and we believe beneficial—impact on health insurance choices and thus health care costs.

In addition, competitive health insurance and health care systems for medicare recipients would yield similarly favorable results. Thus, the voucher concept proposed by Congressman Richard Gephardt, in our judgment, deserves careful consideration.

Thank you very much, Mr. Chairman.

[The prepared statement follows:]

STATEMENT OF HAROLD O. BUZZELL, PRESIDENT, HEALTH INDUSTRY MANUFACTURERS ASSOCIATION

Mr. Chairman and members of the subcommittee, my name is Harold O. Buzzell. I am President of the Health Industry Manufacturers Association (HIMA), a trade association representing more than 260 manufacturers of health care products. We appreciate this opportunity to present what we believe is HIMA's special perspective on proposals to stimulate health care competition.

Our perspective is special because, as both suppliers of health care products and as employers, HIMA members are in a position to evaluate potential effects of the proposals in both the marketplace and the workplace. Our testimony today will focus on these effects, particularly employment-related effects, which we will evaluate on the basis of multi-industry data we have assembled.

You have heard previous witnesses articulate a wide range of views on health care competition. The thought I want to leave with you today is this: HIMA supports competition as the best method for injecting rational incentives into the financing and delivery of health care.

HIMA first publicly endorsed the concept of competition in testimony before this Subcommittee on February 25, 1980. Last week, the Association's Board of Directors reaffirmed its support for that concept by specifying four objectives that a competitive system should attain. A listing of those objectives is attached to my testimony.

THE REASONS HIMA SUPPORTS COMPETITION

Why does HIMA support competition? There are three principal reasons.

First, as employers that pay a large part of the health insurance premiums of tens of thousands of workers, HIMA members have a keen interest in dampening increases in health care costs. While it could conceivably constrict markets for the medical products we make, competition, in our judgment, would moderate health care costs—costs which, as employers, we now consider to be intolerable. These costs contribute to general inflation, impede the ability of firms to compete in world markets, and take a disproportionate toll on small companies.

Second, HIMA members believe competition would control costs in a fashion less onerous than alternative methods. Our reasoning proceeds from the assumption that government will not preside passively over rapidly rising health care expenditures; that something will be done to contain costs.

We believe regulatory approaches to cost containment are inherently inequitable and inefficient. In its extreme form, regulation, such as that in place in Britain, rations health care by restricting patient access to the care or arbitrarily retarding growth of the system. As an industry built on the discipline of free enterprise, HIMA members prefer the rigors of the marketplace to government regulation.

Our third reason is premised on logic: Competition makes sense. The health care system today contains incentives for overinsurance and overutilization, which drive up costs. Simply put, first dollar insurance and retroactive reimbursement for care create incentives for consumers to seek—and the system to provide—more care than is needed. Can anyone take serious issue with the notion that lack of a financial stake in the purchase of health care leads to more health care being purchased?

The solution to the problem, in our judgment, is to modify the incentives which led to the problem in the first place. To do this, HIMA believes all segments of the health care system should be given positive incentives to consider price when making decisions. In particular, firms should be given positive incentives to offer employees insurance choices, and employees should consider plan costs as well as benefits when making their selections. With price-conscious consumers, employers, insurers, and providers in the marketplace, we believe health care costs will moderate without compromising the quality of services delivered.

THE NEED FOR DATA TO EVALUATE THE EFFECTS OF COMPETITION PROPOSALS

While we believe incentives in the health care system should be modified, we believe just as firmly that proposals intended to effect the modifications should receive meticulous scrutiny. In its previous testimony, HIMA told this Subcommittee: "We should guard against well-intentioned measures that do not produce desired results, or do produce undesired results." We continue to believe that potential effects of competition proposals should be carefully evaluated.

To do this, HIMA submits that empirical evidence is needed. Accordingly, for the past two years we have assembled information on the potential effects of various competition proposals.

The data we discuss with you today is the most recent and comprehensive we have collected. It allows us to estimate how selected aspects of the competition proposals would affect private sector health insurance in various industries. We believe this information to be the best available on the subject and will devote most of our testimony to discussing it.

SHORT-TERM EFFECTS OF THE COMPETITION PROPOSALS

Much of the current debate on competition has been of a conceputal nature. To add an empirical component to the debate, HIMA has assembled and analyzed a profile of current group health insurance plans for U.S. private nonagricultural employers. While we draw no conclusions about the proper course for policymaking, we believe the results are instructive and will prove useful to the Subcommittee in evaluating competition proposals.

Since there is a broad range of issues associated with the term "competition," we will focus on five we consider to be significant. These first two relate to characteristics of private group health insurance; the remaining three to ways existing tax and benefit policies could be altered to bring more price consciousness into the private group insurance market.

The five issues are the following:

1. The extent of private group health insurance coverage in the United States.
2. The levels of premium cost of employee group health insurance, the extent to which employers contribute to plans, and the distribution of employer contributions by number of workers in different industries.

3. The tax impacts of placing a limit on the exclusion from employee income of employer contributions to group health insurance.

4. The financial incentives that low cost insurance choices would provide to workers.

5. The impacts which tax exclusion limits would have on the competitiveness of Health Maintenance Organizations.

In general, we find that competitive tax or regulatory policies aimed at group health insurance plans can have a sizable impact on health insurance purchases and, ultimately, health costs. Specifically, employers pay upward of 90 percent of all employee premiums, and measures to limit the tax exclusion of those benefits could cause many workers to reevaluate their insurance purchases. Furthermore, the addition of low-cost insurance options would prove attractive to many workers at current contribution levels, provided that adverse selection could be controlled. Finally, policy changes aimed at private group insurance may affect enrollments in HMOs and other prepaid comprehensive plans.

A more detailed analysis of the data follows.

GROUP HEALTH INSURANCE COVERAGE

HIMA estimates that the great majority of American workers are covered by a health insurance plan at their place of employment. We estimate that in 1981 67.4 percent of all U.S. private sector employees are enrolled in an employer-based group health insurance plan. Coverage ratios vary widely across industries. In manufacturing, mining, and communications, they approach 90 percent, while in somewhat lower paying industries, such as services and trade, they reach only 50 percent. This information is contained in Table 1, which is attached to my testimony.

It is important to note that many employees not covered in the workplace have individual or non-employer based group insurance. So do many of the self-employed. When all such forms of coverage are considered, over 90 percent of employees have health insurance protection, according to the Congressional Budget Office.

For public policy purposes, these figures indicate two things. First, competitive tax or regulatory policies aimed at employer-paid group health insurance could potentially instill cost-consciousness in almost two-thirds of the private sector labor force. Second, given the wide variation in coverage rates across industries, policy changes should avoid discouraging those not currently covered from obtaining insurance that suits their needs.

PREMIUM COSTS, EMPLOYER CONTRIBUTIONS, AND THE DISTRIBUTION OF WORKERS BY EMPLOYER CONTRIBUTIONS

Table 2 presents a summary of the estimated monthly average premiums and employer contributions to family and individual insurance coverage by industry in 1981. The average employer contribution per employee is $82 per month, $106 for family plans and $43 for individuals. Employer contributions for health plan premiums vary substantially across industries, however, in much the same fashion as coverage rates.

We believe the key point disclosed by this table is that, regardless of industry, employers on average pay most of the cost of employee health insurance. In manufacturing, mining, construction, and some others, the employer share exceeds 90 percent. At the low end of the range, the trade and service industry share exceeds 70 percent.

Many analysts say this high employer share is to be expected, since under current tax law employer contributions are excluded from employee income. This provides a substantial amount of tax-free compensation to employees—compensation which, in the aggregate, we estimate to be $40 billion in 1981.

Table 3 presents a distribution of the number of workers covered by family group plans by level of employer contribution. This table depicts variations in employer insurance contributions for workers in different industries. For example, there are almost four million workers—mostly in manufacturing, transportation, and communications and public utilities—who receive monthly employer contributions for family health insurance in excess of $150. This means that these four million workers—nearly one-seventh of those enrolled in family plans—receive tax free compensation for health insurance totaling at least $150 monthly.

An important issue is whether the Congress should place an upper limit on this exclusion from employee income to discourage overinsurance and its potential impact on demand for medical care. Our data permits us to estimate impacts of various limits—an analysis we will provide in the next portion of our testimony.

TAX IMPACTS OF VARIOUS LIMITS ON THE EXCLUSION OF EMPLOYER HEALTH INSURANCE CONTRIBUTIONS FROM EMPLOYEE INCOME

The subsidy which current law accords to employer contributions to employee health plans encourages employees to purchase more health insurance through their employers than they might if the value of the benefit were taxed. It also gives employers and insurers less incentive to offer workers low cost coverage. Though the premium exclusion serves as an inducement to protect against medical emergencies, a reasonable limit on the the exclusion might discourage overinsurance. Under such a limit, individuals could purchase as much insurance as they desire, although employer contributions above the limit would be taxed.

Table 4 presents HIMA's estimates of the impacts of limiting the monthly tax-free employer contributions to employee family[1] health insurance plans to $75, $100, $125, and $150. To illustrate these effects, we will focus on the $125 monthly limit for family coverage that Senator Durenberger proposes in his bill, S. 433. Our calculations take into account the tax cuts recently enacted by the Congress.

If a $125 monthly limit were in effect, we estimate that, at current contribution rates, 6.4 million workers, or 21 percent of the covered family enrollees, would exceed the limit. If employer contributions remained the same, these workers would pay an average monthly tax of $18, or $1.4 billion in the aggregate, to maintain their coverage.

Furthermore, any additional insurance bought by such beneficiaries would be purchased with after-tax dollars, thus encouraging greater employer and employee cost-consciousness in adding benefits.

Because their tax consequences are based on ultimate employee insurance choices, not predetermined exclusion limits, H.R. 850, introduced by Representative Gephardt, and S. 139, introduced by Senator Hatch, do not lend themselves to clear-cut analysis. Both bills, however, imply limits on the tax subsidy for insurance purchases and move in the same direction as S. 433. We believe that the choice of methodology and the appropriate level at which to limit the subsidy are issues that deserve additional study. HIMA will be glad to work with the Subcommittee on this issue.

FINANCIAL INCENTIVES OF LOW-OPTION INSURANCE CHOICES

Another important issue is whether insurers and providers should be encouraged to develop, and employers to make available, a wider range of health plan options that more adequately fit the needs of employees. The lack of true health insurance choices limits worker access to plans that provide cost-conscious features, such as copayments, deductibles, and provider risk-sharing.

Tables 5, 6, and 7 compare the cost of several low-cost insurance plans to the current level of employer contributions. The purpose of these comparisons is to determine how many employees would be eligible for an employer rebate for choosing a low cost plan if offered, and what the size of the monthly rebates would be. The tables show those figures for three low option plans, each of which provides major medical coverage to a family or individual with a 25-percent copayment provision up to a maximum annual catastrophic level of $3,500. The per person deductibles for these plans vary from $130 to $235 per year, and as a result the plan premiums vary as well. While the low option plans we have used in the analysis do not correspond precisely to the minimum requirements of the benefit packages in the pending bills, we believe they provide a fair basis for estimating the incidence and magnitude of rebates.

Our table illustrates that for many employees, the addition of low option insurance could be quite attractive. [This analysis, however, does not tell us how many would actually enroll.] In Table 6, for example, a low option plan costing $75 monthly for a family would, if offered to all U.S. workers, make over 50 percent eligible for a rebate [assuming current contribution levels did not change]. Furthermore, the average rebate would be $51 per month—not an insubstantial sum.

Table 8 shows the rebates that would be available to workers who sought more comprehensive financial protection. The table discloses that an option with a $130 deductible would make 35 percent of all family enrollees eligible for a $45 average monthly rebate.

The addition of low-cost options with rebates has the potential to encourage adverse selection—both by plans seeking to enroll the best risks and by employees self-selecting based on expected medical needs. Unfortunately, our data base cannot address these issues. We believe, however, that any such adverse selection could be

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[1] HIMA has estimates of the impacts of similar limits on individual plan contributions. We will be glad to provide them to the Subcommittee upon request.

mitigated by proper controls on enrollment and rebates, as the Health Insurance Association of America, which represents commerical insurers, has stated. Certainly, steps to discourage adverse selection should be an element of any competition bill. Assuming proper safeguards could be implemented, however, we believe, on the basis of our data, that low-cost/multiple options might well be appealing to a large segment of the work force.

POTENTIAL IMPACTS OF EXCLUSIONARY LIMITS ON HEALTH MAINTENANCE ORGANIZATIONS (HMO'S)

As a final part of its study, HIMA estimated the distribution of monthly family HMO premiums to determine how tax exclusion limits might impact HMO enrollments. Because HMOs have demonstrated an ability to hold down health care costs, some observers have expressed concern that policy changes not be biased against this type of insurance/delivery mechanism.

Table 8 provides a distribution of monthly 1981 HMO premiums for family coverage. Based upon a review of Table 8 and the tax exclusion limits noted above, one can conclude that over 50 percent of HMO members would be potentially affected by tax exclusion limits of $125 or less per month. The extent to which enrollees would be taxed, however, depends upon the current employer contributions, which we do not know. Under a $150 family limit, the impact would be substantially less, with roughly 13 percent of all HMO members potentially affected [assuming employer contributions exceeded $150].

A caveat: The current structure of HMO premiums could change if an exclusionary limit were put into effect. In addition, one should keep in mind that since HMOs provide comprehensive insurance coverage, they would still be attractive to those wishing such coverage in a more competitive, cost-conscious system.

Although we believe the five issues discussed above to be important, there are other elements of competition that require attention. We would like to touch upon two such elements today.

ADDITIONAL COMPETITION ISSUES

Medicare and medicaid

We believe that a truly competitive health care system should not exclude significant groups of purchasers and utilizers of health care. Medicare and Medicaid beneficiaries spend upwards of $60 billion annually on health care in a system that is closed to individual choice and competition and contains many cost-raising incentives. In addition, current mechanisms to contain reimbursement for these programs shift significant program costs to private payers. A continuation of this trend would weaken the efficiency that competitive incentives would instill in private insurance markets.

We believe, therefore, that structural reform in Medicare and Medicaid should accompany any efforts to inject competition into the private sector. Several mechanisms have been proposed to begin this process, including making enrollment in HMOs more attractive for beneficiaries and providing vouchers to purchase private sector insurance. We encourage the Subcommittee to evaluate these proposals carefully.

Teaching hospitals

Teaching hospitals of necessity have higher treatment costs due to their multifaceted roles in providing care to patients, training new health professionals, and conducting research. In a system with a strong emphasis on cost as well as quality of care, these facilities would have difficulty competing for patients and at the same time maintaining a strong commitment to education and research.

Currently, teaching hospital costs are funded from a variety of sources, a major one being higher Medicare and Medicaid reimbursements than those received by non-teaching facilities. Under a competitive system, such funding would be limited.

Some form of direct government subsidy for teaching and research would appear to be the best mechanism to substitute for these current "reimbursement waivers." This approach is desirable for two reasons. First, it would allow the government to determine prospectively the amount of public funds to allocate to teaching and research. Second, it would encourage tertiary care hospitals to deliver services efficiently due to the constraints of a competitive medical marketplace.

Whatever funding mechanism is employed, HIMA believes the special needs of teaching hospitals should be addressed in any proposal to promote greater health care competition.

CONCLUSION

HIMA appreciates this opportunity to testify on health care competition and stands ready to assist the Subcommittee and its staff.

Objectives of health care competition

HIMA endorses the four following objectives of health care competition:

The health care financing and delivery system should be restructured to give consumers, employers, insurers, and providers more incentive to consider price as well as quantity and quality in making health care decisions.

Insurers and providers should be encouraged to develop, and employers and public assistance programs to make available, a wider choice of health plans that more adequately fit the needs of consumers.

Restructuring should be accomplished by modifying tax, public assistance, and regulatory policies that discourage the health care industry from functioning in a competitive market setting.

The resulting competitive system should emphasize individual choice constrained by limited resources, not government decisionmaking, as the principal mechanism for determining total medical expenditures, the utilization of health services, and the allocation of resources.

TABLE I

ESTIMATES OF COVERAGE RATES AND THE NUMBER OF COVERED JOBS IN 1981

	Coverage Rates	Covered Employment (in thousands)
Manufacturing	89.7%	18,174
Mining	91.1%	858
Construction	68.3%	2,902
Transportation	85.2%	1,984
Communications and Public Utilities	94.7%	2,379
Finance, Insurance, and Real Estate	73.2%	3,879
Trade	53.2%	10,911
Service	50.8%	9,402
Total	67.4%	50,484

TABLE 2

SUMMARY OF PREMIUMS

INDUSTRY	AVERAGE EMPLOYER CONTRIBUTION: FAMILY & INDIVIDUAL	AVERAGE EMPLOYER CONTRIBUTION: FAMILY COVERAGE	AVERAGE EMPLOYER CONTRIBUTION: INDIVIDUAL COVERAGE	AVERAGE TOTAL PREMIUM	AVERAGE PREMIUM FOR FAMILY COVERAGE	AVERAGE PREMIUM FOR INDIVIDUAL COVERAGE
MANUFACTURING.......	$82.88	$106.33	$43.02	$88.59	$114.49	$44.54
MINING..............	100.58	122.30	48.67	105.10	128.14	50.05
CONSTRUCTION........	41.71	52.48	22.97	45.31	57.22	24.58
TRANSPORTATION......	92.08	115.19	48.44	95.74	119.45	50.94
COMMUNICATIONS & PUBLIC UTILITIES...	103.96	131.29	49.52	109.72	139.05	51.29
FINANCE, INSURANCE & REAL ESTATE.......	71.28	94.15	46.80	88.12	121.34	52.55
TRADE...............	44.26	55.44	27.14	56.08	72.16	31.43
SERVICES............	41.30	55.23	27.22	54.90	78.67	30.89
Total...............	$65.39	$85.33	$35.91	$74.51	$98.55	$38.94

TABLE 3

PROFILE OF THE NUMBER OF EMPLOYEES WITH FAMILY COVERAGE BY EMPLOYER CONTRIBUTION LEVEL

		INDUSTRY							
	Total	MANUFACTURING	MINING	CONSTRUCTION	TRANSPORTATION	COMMUNICATIONS & PUBLIC UTILITIES	FINANCE, INSURANCE & REAL ESTATE	TRADE	SERVICES
EMPLOYER CONTRIBUTION FOR FAMILY PLAN									
$.00-9.99............	863,770	208,995	-	98,371	10,966	-	4,467	303,363	237,608
$10.00-19.99.........	1,463,802	323,527	-	130,062	10,028	-	-	470,537	529,647
$20.00-29.99.........	1,716,198	306,718	-	152,783	27,448	16,480	58,257	497,410	657,102
$30.00-39.99.........	2,232,615	487,688	65,499	237,919	21,129	36,384	206,590	716,782	460,624
$40.00-49.99.........	2,688,149	736,467	1,709	290,340	34,591	19,354	112,992	895,014	597,682
$50.00-59.99.........	3,175,582	875,032	-	253,403	13,125	16,880	139,710	1,528,391	349,041
$60.00-69.99.........	1,851,059	679,242	42,603	158,105	48,846	6,375	22,700	460,899	432,289
$70.00-79.99.........	1,634,983	444,808	1,174	210,002	42,119	29,084	165,307	378,794	363,696
$80.00-89.99.........	1,894,584	674,942	9,994	143,019	83,869	78,104	273,337	358,120	273,199
$90.00-99.99.........	2,558,482	1,346,679	2,265	89,161	133,049	60,518	306,436	444,865	175,511
$100.00-109.99.......	1,520,159	833,397	21,648	74,863	60,568	86,488	45,716	128,153	269,325
$110.00-119.99.......	1,748,032	570,361	112,448	4,216	477,032	180,752	151,549	141,635	110,040
$120.00-129.99.......	1,306,197	598,742	1,375	490	49,806	162,148	211,934	127,737	153,966
$130.00-139.99.......	1,110,143	309,155	236,397	-	6,492	389,163	90,676	40,813	37,447
$140.00-149.99.......	786,630	456,445	-	-	53,326	172,591	-	59,079	45,189
$150.00-159.99.......	906,453	564,159	3,075	-	-	247,255	43,193	30,683	18,086
$160.00-169.99.......	366,305	142,039	47,131	-	16,777	101,039	59,319	-	-
$170.00-179.99.......	312,438	214,177	-	-	22,230	55,312	-	20,720	-
$180.00-189.99.......	350,378	143,879	-	-	163,600	22,848	20,050	-	-
$190.00-199.99.......	243,431	115,072	59,515	-	18,081	50,764	-	-	-
$200.00-209.99.......	545,383	484,229	-	-	-	-	61,153	0	-
$210.00-219.99.......	177,728	148,524	-	-	4,024	11,311	-	-	13,868
$220.00-229.99.......	555,025	543,561	-	-	-	11,464	-	-	-
$230.00-239.99.......	15,639	15,639	-	-	-	-	-	-	-
$240.00+.............	258,079	220,523	-	-	-	5,609	31,947	-	-
Total................	30,281,243	11,444,000	604,834	1,842,735	1,297,105	1,759,922	2,005,334	6,602,995	4,724,319

TABLE 4

TAX IMPACT OF LIMITING THE TAX-FREE EMPLOYER CONTRIBUTIONS TO FAMILY HEALTH INSURANCE PLANS

	$75 Limit	$100 Limit	$125 Limit	$150 Limit
Number of employees currently above the limit.	15,391,440	10,189,950	6,402,836	3,708,810
Per centage of all family plan enrollees above the limit.	50.8	33.7	21.1	12.2
Average monthly tax per employee	$20	$19	$18	$17
U.S. aggregate annual tax revenue * (billion)	$3.7	$2.3	$1.4	$.76

*Additional revenue would be produced by limiting tax-free individual contributions.

TABLE 5

ESTIMATED AVERAGE PREMIUM, EMPLOYEES AFFECTED AND AVERAGE REBATE FOR LOW OPTION COVERAGE: $235 DEDUCTIBLE

	MONTHLY PREMIUM: FAMILY COVERAGE	MONTHLY PREMIUM: INDIVIDUAL COVERAGE	EMPLOYEES ELIGIBLE: FAMILY & INDIVIDUAL COVERAGE	EMPLOYEES ELIGIBLE: FAMILY COVERAGE	EMPLOYEES ELIGIBLE: INDIVIDUAL COVERAGE	PERCENT OF EMPLOYEES ELIGIBLE: FAMILY & INDIVIDUAL	PERCENT OF EMPLOYEES ELIGIBLE: FAMILY	PERCENT OF EMPLOYEES ELIGIBLE: INDIVIDUAL	AVERAGE REBATE: FAMILY & INDIVIDUAL	AVERAGE REBATE: FAMILY	AVERAGE REBATE: INDIVIDUAL
INDUSTRY											
MANUFACTURING.......	$76.00	$32.50	11,872182	7,591,558	4,280,624	65.3%	66.3%	63.6%	$47.6	$61.4	$23.1
MINING..............	75.00	30.50	721,639	495,023	226,616	84.1	81.8	89.5	50.4	63.7	21.4
CONSTRUCTION........	76.00	32.50	641,353	399,108	242,244	22.1	21.7	22.9	11.2	13.5	7.3
TRANSPORTATION......	75.00	30.50	1,657,387	1,096,077	561,310	83.5	84.5	81.7	42.9	52.6	24.0
COMMUNICATIONS & PUBLIC UTILITIES..	74.50	28.00	2,507,627	1,651,544	856,083	94.9	93.8	96.9	48.7	62.4	22.4
FINANCE, INSURANCE & REAL ESTATE.......	75.00	31.50	2,694,614	1,330,921	1,363,693	69.5	66.4	72.8	33.2	42.6	24.1
TRADE...............	71.00	30.00	2,979,323	1,654,743	1,324,581	27.3	25.1	30.7	23.2	28.3	16.8
SERVICES............	73.50	31.00	2,769,982	1,348,313	1,421,669	29.5	28.5	30.4	21.8	27.2	16.7
Total...............	$74.30	$31.25	25,844106	15,567286	10,276819	50.9%	51.4%	50.2%	$39.5	$51.6	$21.1

TABLE 6

ESTIMATED AVERAGE PREMIUM, EMPLOYEES AFFECTED AND AVERAGE REBATE FOR LOW OPTION COVERAGE: $160 DEDUCTIBLE

	MONTHLY PREMIUM: FAMILY COVERAGE	MONTHLY PREMIUM: INDIVIDUAL COVERAGE	EMPLOYEES ELIGIBLE: FAMILY & INDIVIDUAL COVERAGE	EMPLOYEES ELIGIBLE: FAMILY COVERAGE	EMPLOYEES ELIGIBLE: INDIVIDUAL COVERAGE	PERCENT OF EMPLOYEES ELIGIBLE: FAMILY & INDIVIDUAL	PERCENT OF EMPLOYEES ELIGIBLE: FAMILY	PERCENT OF EMPLOYEES ELIGIBLE: INDIVIDUAL	AVERAGE REBATE: FAMILY & INDIVIDUAL	AVERAGE REBATE: FAMILY	AVERAGE REBATE: INDIVIDUAL
INDUSTRY											
MANUFACTURING.......	$90.00	$37.00	10,464301	6,694,319	3,769,982	57.6%	58.5%	56.0%	$42.7	$54.6	$21.5
MINING...............	90.00	34.50	684,378	483,855	200,523	79.8	80.0	79.2	41.1	49.9	19.8
CONSTRUCTION.........	90.00	37.00	326,666	168,731	157,935	11.3	9.2	14.9	7.3	8.8	5.7
TRANSPORTATION.......	90.00	34.50	1,521,840	1,004,984	516,855	76.7	77.5	75.3	34.7	41.4	21.8
COMMUNICATIONS & PUBLIC UTILITIES..	93.00	31.25	2,369,407	1,557,261	812,145	89.6	88.5	91.9	37.9	47.1	20.3
FINANCE, INSURANCE & REAL ESTATE.......	89.00	36.25	2,204,372	1,057,565	1,146,808	56.8	52.7	61.2	30.0	37.2	23.4
TRADE...............	85.50	35.00	2,230,669	1,231,046	999,623	20.4	18.6	23.2	19.0	21.1	16.5
SERVICES............	86.50	36.00	1,929,114	859,604	1,069,510	20.5	18.2	22.9	20.9	26.5	16.3
Total...............	$88.58	$35.92	21,730745	13,057364	8,673,382	42.8%	43.1%	42.4%	$35.4	$45.5	$20.1

TABLE 7

ESTIMATED AVERAGE PREMIUM, EMPLOYEES AFFECTED AND AVERAGE REBATE FOR LOW OPTION COVERAGE: $130 DEDUCTIBLE

	MONTHLY PREMIUM: FAMILY COVERAGE	MONTHLY PREMIUM: INDIVIDUAL COVERAGE	EMPLOYEES ELIGIBLE: FAMILY & INDIVIDUAL COVERAGE	EMPLOYEES ELIGIBLE: FAMILY COVERAGE	EMPLOYEES ELIGIBLE: INDIVIDUAL COVERAGE	PERCENT OF EMPLOYEES ELIGIBLE: FAMILY & INDIVIDUAL	PERCENT OF EMPLOYEES ELIGIBLE: FAMILY	PERCENT OF EMPLOYEES ELIGIBLE: INDIVIDUAL	AVERAGE REBATE: FAMILY & INDIVIDUAL	AVERAGE REBATE: FAMILY	AVERAGE REBATE: INDIVIDUAL
INDUSTRY											
MANUFACTURING.......	$100.00	$41.00	8,438,565	5,347,640	3,090,925	46.4%	46.7%	45.9%	$44.1	$57.0	$21.9
MINING..............	100.00	38.00	639,425	481,590	157,835	74.5	79.6	62.4	35.4	40.1	21.2
CONSTRUCTION........	100.00	41.00	177,603	79,570	98,033	6.1	4.3	9.3	4.6	5.0	4.3
TRANSPORTATION......	100.00	38.00	1,351,940	871,935	480,005	68.2	67.2	69.9	30.8	36.8	19.8
COMMUNICATIONS & PUBLIC UTILITIES..	101.00	35.00	2,249,123	1,496,744	752,379	85.1	85.0	85.2	33.2	40.9	18.0
FINANCE, INSURANCE & REAL ESTATE.......	97.50	39.50	1,799,859	715,537	1,084,322	46.4	35.7	57.9	30.4	44.0	21.
TRADE...............	92.50	37.50	1,735,991	940,574	795,417	15.9	14.2	18.5	18.8	19.7	17.
SERVICES............	93.50	39.50	1,632,803	766,245	866,558	17.4	16.2	18.5	19.3	22.4	16.
Total...............	$97.24	$39.39	18,025308	10,699835	7,325,473	35.5%	35.3%	35.8%	$35.0	$45.3	$19.

TABLE 8

ESTIMATED DISTRIBUTION OF HMO PREMIUMS NATIONALLY FOR FAMILY COVERAGE ---- 1981

	Family Coverage	
Estimated 1981 Monthly Premium	Number of HMOs	1980 Enrollment in HMOs by Their Estimated 1981 Premium
0-59.99	0	0
60.00-69.99	1	52,280
70.00-79.99	1	20,239
80.00-89.99	5	34,479
90.00-99.99	13	116,489
100.00-109.99	15	2,974,103
110.00-119.99	28	605,129
120.00-129.99	30	599,303
130.00-139.99	37	2,272,756
140.00-149.99	36	809,088
150.00-159.99	23	814,826
160.00-169.99	8	276,345
170.00-179.99	5	59,365
180.00-189.99	1	22,310
190.00+	0	0
Total[1]	203	8,656,712

TO ACCOMPANY THE TESTIMONY OF THE
HEALTH INDUSTRY MANUFACTURERS
ASSOCIATION

Profile of U.S. Employees with Family Coverage by Level of Monthly Employer Contribution

Total	**30,281,244**
EMPLOYER CONTRIBUTION FOR FAMILY PLAN:	
$0-49	**8,964,534**
$50-99	**11,114,690**
$100-149	**6,471,161**
$150-199	**2,179,005**
$200 Plus	**1,551,854**

Tax Impact of Limiting the Tax-free Employer Contributions to Family Health Insurance Plans

	$75 Limit	$100 Limit	$125 Limit	$150 Limit
Number of Employees currently above the limit	15,391,440	10,189,756	6,402,836	3,708,810
% of all family plan enrollees above the limit	50.8%	33.7%	21.1%	12.2%
Average monthly tax per employee	$20	$19	$18	$17
U.S. aggregate annual tax revenue* (billion)	$3.7	$2.3	$1.4	$.76

*Additional revenue would be produced by limiting tax-free individual contributions

Low Option Insurance —Plan Costs, Employees Eligible for Rebates, and Amount of Monthly Rebates

MONTHLY PREMIUM LOW-OPTION* FAMILY COVERAGE	PERCENT OF FAMILY PLAN ENROLLEES ELIGIBLE FOR REBATES	AVERAGE MONTHLY REBATE PER FAMILY	MONTHLY PREMIUM LOW OPTION* INDIVIDUAL COVERAGE	PERCENTAGE OF INDIVIDUAL PLAN ENROLLEES ELIGIBLE FOR REBATES	AVERAGE MONTHLY INDIVIDUAL REBATE
$74.00	51.4%	$52.00	$31.00	50.2%	$21.10

*Low Option Insurance is Major Medical Coverage—$235 deductible, 25% co-insurance to a catastrophic level of $3500 per year per family.

Chairman **Jacobs**. We thank you, sir.

Mr. Rangel.

Mr. **Rangel**. No questions.

Chairman **Jacobs**. On the voucher question, I take it you mean for medicare?

Mr. **Buzzell**. Yes.

Chairman **Jacobs**. Do you see any problem on that for the very elderly and somewhat feeble, somewhere between imparity and guardianship?

Mr. **Buzzell**. No, I do not. I would not mandate the voucher immediately. I certainly believe there would have to be provisions to take care of the very elderly if, in fact, the implication is that they are senile or unable to make decisions for themselves.

I think the voucher is a workable concept.

Chairman **Jacobs**. You say that, I take it, even in view of the so-called Medigap insurance scandals. We thank you very much for your contribution.

Mr. **Buzzell**. Thank you, sir.

Chairman **Jacobs**. The next witnesses will please come forward.

Mr. Frederick, just identify yourself and your organization and proceed.

STATEMENT OF EARL J. FREDERICK, MEMBER, ADMINISTRATIVE BOARD, COUNCIL OF TEACHING HOSPITALS, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND PRESIDENT, CHILDREN'S MEMORIAL HOSPITAL OF CHICAGO, ACCOMPANIED BY JAMES D. BENTLEY, ASSOCIATE DIRECTOR, DEPARTMENT OF TEACHING HOSPITALS

Mr. **Frederick**. Mr. Chairman, members of the committee, I am Earl Frederick, president of the Children's Memorial Hospital of Chicago and member of the administrative board of the Association's Council of Teaching Hospitals. Accompanying me is James Bentley, associate director of the Association's Department of Teaching Hospitals.

We are now approaching the end of a long hearing on a complicated subject. From what I have heard this morning and from reports I have received about previous days, much of the testimony presented has emphasized philosophical positions and policy concepts. I have submitted a written statement for the record which addresses the major concerns teaching hospitals have with competition; namely, adequate coverage for the poor and financing the societal contributions provided by teaching hospitals. Rather than reiterate these points this morning, I would like to take a few minutes to describe price competition from the perspective of one tertiary care and teaching hospital. I hope this will help you understand my concerns and reservations.

Children's Memorial Hospital, with 265 beds, is located on the near north side of downtown Chicago. We are a referral center for infants and children with major medical problems, because the closest children's hospitals are in Detroit, St. Louis, Milwaukee, and Memphis. We are also a primary care site for many intercity Chicago residents; 65 percent of our outpatient visits come from a 5-mile radius of the hospital. Last year 96 residents and fellows received training in our hospital. Their stipends and benefits amounted to $2,100,000 or 3.4 percent of the hospital's operating budget. To help advance our knowledge of children's diseases and developmental problems, hospital staff participated in 200 funded research projects with total expenditures of $2.3 million. Last year, 11,112 children were admitted to our hospital and 134,000 outpatient visits were provided. In summary, I believe we provide valuable patient services to today's children, both close at hand and from afar, and important educational and research investments for the future.

As my staff and I consider a price-competitive marketplace for hospital services, we envision Children's Memorial trying to compete with four major disadvantages. It is generally agreed that teaching hospitals will be able to compete quite well for the high-cost tertiary care, as that is probably the case for our hospital. However, the disadvantages, as we see them, first, we are located in an area of the city that is not particularly attractive to well-insured surburban patients to come to our setting for care. Avoiding total relocation of the hospital, we must attract paying patients to an area they often avoid, particularly for nontertiary care.

Second, because of our urban location, the hospital provided $2.3 million of charity care last year and a writeoff of $6.8 million in bad debts. These services are subsidized by paying patients, donations, and lowered hospital income. If we have to compete on the basis of price and still provide care for patients who cannot pay, we will be competing at a substantial disadvantage to other hospitals with fewer charity patients.

Third, the State of Illinois is implementing a major medicaid cutback. Last year, 27 percent of our inpatients and 38 percent of our outpatients were supported by medicaid. The present Illinois cutback will reduce hospital revenues by $4 million in our current fiscal year, a reduction that will increase the need for charity care services. I am concerned that price competition will enhance this situation.

Fourth, parents always envisage creating a healthy, mature newborn. Unfortunately, this is often not the case. Last year, Children's Memorial provided 8,000 patient days of care for infants who were born premature and referred to our hospitals as we are not a hospital providing obstetrical services. Most of these patients survived. Overall, 41 percent of our inpatients are 18 months old or less. These children often consume massive amounts of medical care, and a young family is saved from financial ruin if it has a comprehensive health insurance. The health problems of the newborne strike without warning and without waiting for an open enrollment period. A young family pressed by financial expenses in an inflationary economy may prefer a basic health insurance plan which results in a tax-free rebate. But if they have a seriously ill newborne or infant, the basic plan will require heavy copayments and deductibles that place financial stress on a family undergoing emotional stress. Inadequate coverage will also decrease hospital cashflow and increase charity care.

In short, I understand the economists point that hospitals respond to the economic incentives before them. I have seen it happen in the past and expect it will continue in the future. But today's hospitals reflect the economic realities of the past. Some of our hospitals are well-situated for a price competitive marketplace; others are not, for they are disadvantaged by location, patient population and long-term educational and technological transfer programs. Therefore, while I find it more exciting to think about the management challenges and rewards of a price-competition marketplace, I have deeply felt genuine concerns about rapidly implementing an untried theoretical approach, which places some patients in hospitals at substantial risk.

Thank you.

[The prepared statement follows:]

STATEMENT OF EARL FREDERICK, ASSOCIATION OF AMERICAN MEDICAL COLLEGES

I am Earl Frederick, President of the Children's Memorial Hospital of Chicago and member of the Administrative Board of the Association's Council of Teaching Hospitals. Accompanying me is James Bentley, Associate Director of the Association's Department of Teaching Hospitals.

Hospitals in the Association's Council of Teaching Hospitals account for 18 percent of the admissions and 31 percent of the outpatient visits provided by all nonfederal short term hospitals. These hospitals provide routine medical services for many of our citizens and the most complex, lifesaving, tertiary care services for all of our citizens. They are the primary sites for the patient component of physician training and the major centers for transferring new diagnostic and treatment technologies from the laboratory to the bedside. As a result of these multiple missions, teaching hospital costs are generally higher than non-teaching hospitals. Therefore, proposals which have been developed to stimulate price competition in the health care field merit careful evaluation.

The Association has no special expertise in assessing alternative tax reform proposals. We also are not in a position to evaluate the economic consequences competition will have on the total dollars presently spent on health care in this Nation. The Association does believe, however, that we have an obligation to raise several questions about competition which have to date received inadequate attention in public forums. Hopefully, consideration of these issues will help to avoid unintended consequences of intended worthy objectives.

The Association believes that all of the present "pro-competition" proposals will stimulate price competition among hospitals. In some proposals, the stimulus to price competition would be direct and explicit with existing regulations and cost-based reimbursement programs repealed. With these changes, it is assumed that third party payers would enter into price sensitive arrangements for providing and purchasing medical care services. Other proposals, which seek to stimulate consumer choice in the selection of health insurance, would indirectly but inevitably stimulate price competition among hospitals by providing insurers with a major incentive to enter into price sensitive arrangements for providing and underwriting medical care services.

It is important to remember that there has been no wide-scale experience with these approaches. This is particularly significant because the proponents of price competition among hospitals have not addressed the potential implications of these approaches for certain types of providers, patient populations, and the nation's supply of trained health manpower. If our nation is to retain the strengths of the present system of medical care, the following questions about the possible consequences of competition must be posed and answered:

Which institutions will most negatively be affected? Are those the ones that should be cutting back or closing their doors?

What services will be encouraged? Will there be an excess of services that can be aggressively priced and marketed to healthy populations at the expense of services for the seriously ill and underserved populations?

Who will treat indigent patients in the inner city, rural areas, or other locations if it is "bad business" to provide care in those environments?

Will all patients, regardless of geographic location and financial status, have reasonable access to an adequate level and scope of services?

Will sufficient incentives or standards exist to assure quality care when choices are presented in terms of their price?

In other words, although price competition will influence decisions by consumers and groups with purchasing power, there are no assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet reasonable needs of all of its citizens.

For the teaching hospital to be competitive in a price dominated marketplace, two broad issues have to be addressed: funding for charity care patients and funding for the unique societal contributions of teaching hospitals. Adequate funding for patients unable to pay for needed health services is not a need unique to teaching hospitals. While teaching hospitals do provide large amounts of uncompensated care, some neighborhood and community hospitals also provide large amounts of uncompensated care.

Hospitals utilized by the poor must subsidize the costs of this care with higher charges to their paying patients. If a hospital has few charity patients, the increase in prices to paying patients will be small and the hospital's competitiveness will not be undermined. However, if the hospital cares for a large number of charity patients, the price increase required for paying patients will be large so that paying patients will be discouraged from using the hospital. As the hospital's proportion of charity care increases, the disincentive to paying patients increases. In a price competition marketplace, hospitals caring for the poor will be at a competitive disadvantage.

To permit hospitals to care for patients unable to pay for the services they need, proposals to restructure the medical care system must include full payment for the costs of caring for the poor. This is contrary to recent administration and congressional decisions to decrease the federal financial commitment to the poor, the medically indigent, and the aged. The trend begun in the recent budget reconciliation process must be reversed if all hospitals are to compete even-handedly on a price basis.

The second issue of major concern for teaching hospitals derives from the added costs teaching hospitals incur in meeting their obligations to society as a whole rather than to individual patients. These societal activities include the clinical components of undergraduate and graduate medical and allied health education, technology transfer and dissemination, community-wide tertiary care services with high standby costs, and primary care ambulatory services in medically underserved areas. Presently, these activities are financed through patient care revenues. Price competition among hospitals raises questions about the future ability of teaching hospitals to finance these responsibilities.

One commonly proposed solution is to identify and separately fund these activities on their own merits. In effect, this approach argues for centralization and regulation of decisions for these activities, but decentralization, through price influenced market mechanisms, of all other decisions relating to patient care services. Efforts to carve out and separately fund unique, socially desirable attributes of teaching hospitals should recognize the potentially negative impacts of this approach:

Separate funding of graduate medical education may limit the ability of medical schools and teaching hospitals to make local decisions about their residency programs.

Federal support for graduate medical education may be subject to the budget and appropriations process which could make such a fund vulnerable to any major efforts to cut federal spending.

The administration of the fund could be extremely complex. How would the necessary funds be collected? How would those responsible for distributing the funds decide which hospitals would get support and what that level of support should be?

As a result of these problems, teaching hospitals have been unable to identify a solution to the problems their societal missions create in a price competitive environment. Nevertheless, a solution must be found.

Each of the issues is described more completely in the Association's publication, "Price Competition in the Health Care Marketplace: Issues for Teaching Hospitals". Copies of that publication have been appended to my statement. In the interest of time, I would request that the publication be included in the hearing record and would welcome the opportunity to address questions you may have.

Association of American Medical Colleges

PRICE COMPETITION IN THE HEALTH CARE MARKETPLACE

"Issues For Teaching Hospitals"

Discussion Paper
Approved by the AAMC
Executive Council
March, 1981

OVERVIEW

Many health economists, business groups, and legislators are advocating fundamental changes in health insurance and medical services to stimulate cost consciousness among providers (hospitals and physicians) and consumers (individuals enrolling in health plans and patients seeking care). These proposals are commonly referred to as the "competitive" approach to cost containment. One approach is designed to influence "consumer choice". It has three underlying principles: employers would be mandated or encouraged to offer multiple choices among health plans to their employees; employers would be required to make the same dollar contribution to an employee's premium regardless of the plan selected; and a dollar limit would be placed on the amount of the premium that could be treated as a deduction for tax purposes. This "consumer choice" level of competition is explicitly articulated in proposed legislation.

A second approach is directed at increasing "price competition" among providers. It assumes that consumer choice principles coupled with the repeal of existing regulations, such as health planning, PSRO's, and cost-based reimbursement, would encourage individuals and health insurance plans acting in behalf of their beneficiaries to give greater consideration to hospital costs and physician fees when purchasing or contracting for health care services. As a result, those providing the services – hospitals, HMOs, physicians – would be stimulated to provide their services at the lowest possible cost. Although quality of care, access, and other factors might influence consumer decisions, it is presumed that an overriding concern for the price of medical services would bring about major cost savings.

Because there has been no wide-scale experience with consumer choice and price competition, it is not certain that these approaches would achieve their objectives. One could speculate that unit costs would be reduced, but total medical care expenditures might not show a corresponding drop. In fact, competition may actually increase total costs because individuals might choose to buy more rather than less third party coverage, and providers would have incentives to market more services and expand their operations. Although these outcomes would not necessarily be undesirable, they would be contrary to the postulated reduction in medical service expenditures that some proponents of price competition believe would occur.

Proponents of price competition have not addressed the potential implications of this approach for certain types of providers, patient populations, and the nation's supply of trained health manpower. If we are to retain the great strengths of our present system of medical care, the following questions about the possible consequences of competition must be posed and answered:

- Which institutions will be most negatively affected? Are those the ones that should be cutting back or closing their doors?
- What services will be encouraged? Will there be an excess of services that can be aggressively priced and marketed to healthy populations at the expense of services for the seriously ill and underserved populations?
- Who will treat indigent patients in the inner city, rural areas, or other locations if it is "bad business" to provide care in those environments?
- Will all patients, regardless of geographic location and financial status, have reasonable access to an adequate level and scope of services?
- Will sufficient incentives or standards exist to assure quality care when choices are presented in terms of their price?
- If some hospitals, in order to compete, are unable to fund depreciation expenses, will funds be available to ensure adequate re-capitalization in the health industry?

In other words, although price competition may stimulate prudent decisions by educated consumers and groups with purchasing power, there are no assurances that those "dollar votes" will result in a medical service system that will achieve the nation's health care goals and meet reasonable needs of all of its citizens.

Teaching hospitals must be concerned about competition because their costs are generally higher than those of non-teaching hospitals. Many of the higher costs of teaching hospitals derive from their educational programs, the nature of the patient case mix, losses on charity care, and their role in the introduction of new and more effective methods for prevention, diagnosis and treatment into medical care. These activities are presently funded by patient care revenues. Under competitive pricing, individual consumers and the third parties, HMOs, and IPAs negotiating on their behalf may be unwilling to pay the cost of programs which provide long term rather than short term benefits. Thus, teaching hospitals may be placed at a distinct disadvantage, and their unique contributions to society threatened. On the other hand, depending on how a free market system is structured, teaching hospitals may be very competitive in those areas of medical care that are not provided by other institutions.

This document provides a basis for assessing the potential impact of competition on teaching hospitals by:

- describing how policy makers and opinion leaders view teaching hospitals under price competition;
- describing price competition within the context of other environmental and health policy changes emerging in the eighties; and
- identifying the critical issues for teaching hospitals under price competition.

HOW THE POLICY MAKERS AND OPINION LEADERS VIEW TEACHING HOSPITALS UNDER COMPETITION

"I can't believe that economics will doom the greatest medical education system in the world. Price, after all, is not always the controlling factor. Hospitals also survive on their reputations, the quality of their medical staff, and their relationships with other institutions."(1)

J. Alexander McMahon
President
American Hospital Association

Although these remarks are reassuring, and the comments may very well be accurate, there is little evidence of any serious consideration given to the implications of price competition for teaching hospitals. *Paul Ellwood,* President, InterStudy, made the following remarks at the 1980 Council of Teaching Hospitals' (COTH) Spring Meeting (2):

> *Perhaps the most important and lengthy change required by competitive pressures will be to revamp the entire system of paying for medical education. For every teaching hospital, whether the teaching mission is cut back or expanded, intensified competition for patient care dollars will be played under a changed and reasonably well-defined set of rules for health delivery, and an evolving and less clearly defined method for funding graduate medical education.*

> *Most teaching hospitals are located in communities with very high rates of hospital utilization, and are therefore, "easy marks" for organizations that can provide high quality care with even moderate reductions in hospital use.*
>
> *I suspect that despite their technological supremacy, most teaching hospitals operate under inhibitions that will prevent them from starting the first (alternative health service) plan in town – inhibitions such as a superstar head of medicine who insists on autonomy, aggravating town/gown disputes; reluctance of the faculty to deliver primary care; and perhaps an unvoiced fear that users of your hospital may pay a high price for its leadership in research and education.*
>
> *The lead time required to prepare academic institutions to be competitive may be from two to five years, and those entering the competitive market late must pay a high price to get back patients who have left them for the earlier competitors.*

Clark Havighurst of Duke University, in an unpublished document titled "Competition in Health Services – An Equal Number of Questions and Answers," made the following comments about education, research, and charity care (3):

> *To a significant though unknown degree, university and some other medical centers are dependent on earning monopoly profits to finance educational and research endeavors. In a competitive world, these resources would undoubtedly be jeopardized. It should be no argument against competition, however, that it deprives the industry of discretionary funds with which it does things it regards as desirable. Nevertheless, new subsidies must be found to replace at least some of those that may be eliminated by competition. Resort to other sources of funding will bring subsidies into the open and will require new social judgments about the appropriateness of each. Society may be unwilling to continue subsidies at the rate they have been involuntarily provided in the past, and some worthy activities may in fact go unfunded.*
>
> *Cross-subsidies within hospitals are currently financing a great deal of indigent care, and competition surely threatens the continuation of these subsidies. In the short run, decisions on certification of need can legitimately protect internal subsidies, but one has to hope that, in the long run, hidden financing will become unacceptable and will be replaced by new public subsidies.*

Alain Enthoven, a leading spokesman for competition, has made the following comments about academic medical centers (4):

> *Today, a great deal of the teaching and research costs of academic medical centers are being piggy-backed onto Medicare and Medicaid patient care costs. However, I believe this funding strategy is going to fail.*
>
> *I am in favor of accurately identifying the costs of teaching and research activities and defending each on its merits and getting it paid on its merits. I recognize that there are problems of joint products and joint costs, but they can be handled. Each function should be paid for on an open and explicit basis rather than in a covert way.*

Eli Ginzberg of Columbia University expressed the concerns about price competition in the New England Journal of Medicine (5):

> *. . . I see nothing but trouble ahead if the nation's teaching hospitals are forced to compete with community hospitals in providing routine services, since the former's per diem costs are 1½ to two times as high as the latter's, as a result of their diverse output, which goes far beyond performing an appendectomy and involves such critically important societal goals as training the next generation of physicians and adding to the pool of knowledge and technique. Enthoven appreciates this challenge, but the CCHP (Consumer Choice Health Plan) has not addressed it adequately.*
>
> *There is nothing in the theory of competition to ensure that the resources required by the poor and the isolated for essential medical care will continue to be available. The recent closure of an increasing number of inner-city hospitals raises a warning that may not be disregarded.*

Walter McNerney, President of Blue Cross and Blue Shield Associations, cited several questions about the impact of competition on teaching hospitals in his recent New England Journal of Medicine article (6):

> *How do we avoid the virtual exclusion from the market of the academic medical centers offering the best – and most expensive – care? How would a price-competitive system accommodate the costs of educating physicians and allied health professionals?*

While several Congressmen who support price competition have indicated that special grants would be provided to teaching hospitals to help support the costs of education, only the Gephardt/Stockman bill has explicitly stated how educational costs would be financed. Section 301 includes the following language (7):

The Secretary shall make grants to, or enter into contracts with, entities (other than educational institutions) to compensate them for not more than 70 percent of the direct costs of providing graduate medical education and training for nurses and other health care professionals through accredited educational programs, to the extent the Secretary finds such compensation is necessary to provide training for needed health care professionals. Such grants and contracts shall be made only with entities which are public or private, nonprofit, charitable organizations.

A summary of the views of those who have addressed the implications of market forces in health care for teaching hospitals suggests that:

- Because of the multiple and joint products teaching hospitals provide (i.e., education, research, tertiary care, and charity care), they do not fit neatly into competitive models. Although some believe that a competitive system can be devised that will treat teaching hospitals equitably, insufficient attention has been given to the implications of price competition for teaching hospitals.
- The societal contributions of the teaching hospitals, with the possible exception of educational programs, have largely been ignored by proponents of competition, and they have advanced no method to preserve these contributions.
- Charity care has been identified as a troublesome issue, but no one has carefully considered the implications of price competition on access to quality care for indigent patients.

COMPETITION WITHIN THE CONTEXT OF OTHER TRENDS IN HEALTH CARE

The proponents have argued that price competition can revolutionize the way health care is organized and provided, reduce the financial incentives perceived to stimulate increased costs, and lower costs while retaining or even improving quality and access to care. These claims are overly optimistic and probably misleading.

The organization and delivery of health care is a dynamic process which is continually responding to societal and economic changes. The American Hospital Association's (AHA) Environmental Assessment of the Hospital Industry for the next three to five years makes the following statements (8):

- The growth of multi-institution arrangements will enhance the coordination of services and the linkage of service systems. Increased interest in HMO development by hospitals and IPAs will focus on what is the role of the existing providers in the development of HMOs, rather than whether an HMO is appropriate.

- The HMO model will be adopted or modified by some hospitals choosing to move away from the exclusive provision of traditional inpatient care and as hospitals explore new sources of revenue and utilization in conjunction with inpatient services. In some instances, this may involve new dimensions in the relationship between hospitals and other sponsors or participants in HMO activity, notably physicians and third party payers.
- Employers will attempt to reduce their outlays for health insurance by proposing modifications in third-party payment systems by offering cost-sharing insurance programs, health incentives, and health education programs to employees, and by participating in and sponsoring HMOs and other alternative delivery mechanisms.
- Physicians will increasingly work in multi-physician teams in treating patients. These teams may develop from group practices created by physicians themselves or from new staff organization methods in hospitals that increase the number of full-time employed physicians.
- The cost of research and teaching conducted at teaching hospitals will increasingly be recognized as a distinct element of the costs incurred by these hospitals. Alternative payment mechanisms will be explored to cover these costs, thus making the cost of patient care at teaching hospitals more readily comparable to costs at non-teaching hospitals.

Most predictions and prescriptions for the medical services of the future ignore quality of care. Pro-competition and regulatory approaches emphasize cost containment and do not provide adequate safeguards to assure the quality of medical care desired by people. As discussion and debate proceed on health care reforms, the following questions should be addressed:

- In the haste to stimulate competitively priced health plans, what assurances are there that access and quality will be of an acceptable level?
- Does the possibility exist, as Robert Heyssel has suggested, that if the fee-for-service system supposedly makes money by doing too much, is it not also true that some HMOs might try to make money by doing too little? (9)
- If primary care physicians, through their participation in prepaid health plans, become increasingly responsible and financially liable

for the total range of services provided to their patients, what provisions can be made to assure that they will refer patients for needed tertiary care?

- Is it possible to assure access to tertiary services by mandating health plan coverage and reinsurance to minimize disincentives to refer?

In theory regulation and price competition represent two very different approaches, but they are not as clearly separable as often portrayed and the potential of either, by itself, to mold the future of the medical services may be overstated. McNerney has articulated this point well by describing what he views as the four cornerstones of medical care in the eighties – regulation, competition, voluntarism, and innovation (6). Many of the changes described by AHA's environmental assessment are already occurring in areas without price competition or heavy regulation. These changes have taken place not because of new concepts on financing and regulating health care, but from economic realities. The potential benefits ascribed to competition or regulation by their advocates will be muted by the country's general economic, political, and social environment from which medical care cannot disassociate itself. Price competition could intensify comparison of costs and utilization among hospitals, experimentation with alternative delivery systems, examination of educational costs, more prudent purchasing of health insurance plans by employers, and regionalization of health services. Regulation might do the same through mandatory cost containment, PSROs, planning legislation, technology guidelines, and incentives for HMOs.

An evaluation of price competition must include but go beyond a discussion of the events that are likely to occur regardless of the financing and regulatory structure. The emphasis should be on the degree to which competition facilitates or impedes those changes and the identification of any events that can be uniquely attributable to price competition.

For teaching hospitals, medical schools, and medical faculty, the main question may be how to influence, anticipate, and organize for the possible changes. The potential for teaching hospitals to expand their relationships with community hospitals, nursing homes, ambulatory care sites, HMOs, attending physicians, medical school faculty, physician assistants, nurse practitioners, the community, and patients will have to be examined. However, given the number of organizations and personalities involved and the important and unique contributions to medicine made by academic medical centers under the current mode of operation, organizational changes may be difficult to achieve. It is within this broad context that the specific implications of competition for teaching hospitals should be addressed by teaching hospital administrators, medical school faculty, and other participants in teaching hospitals and health professional education.

ISSUES FOR TEACHING HOSPITALS

Underlying the competitive models is the assumption that hospitals provide a single, relatively standardized product which is identifiable in terms of costs and quality. This assumption raises several issues for hospitals which have multiple products benefiting not only the individual patient, but society as a whole. Because these activities result in higher average costs, presently financed through patient care revenues, competitive pricing resulting from proposed legislation raises questions about the future ability of teaching hospitals to meet these multiple responsibilities.

Price competition may affect eight specific areas:

- Undergraduate Medical Education,
- Graduate Medical Education,
- Allied Health Sciences Education,
- Applications of Research,
- Tertiary Care and Case Mix,
- Charity Care,
- Ambulatory Care, and
- Faculty Practice Plans.

Undergraduate Medical Education

Total enrollment in U.S. medical schools, which has more than doubled since 1963, now exceeds 65,000. Since the late sixties, greater emphasis has been placed on primary care training. These two developments have created a dramatic increase in the number and variety of clincial clerkships. As a result, although the university-owned and primary affiliate hospitals are still the principal settings for clerkship training, numerous other community hospitals and ambulatory care settings now participate in undergraduate medical education.

There are both direct and indirect costs associated with the education of undergraduate medical students in the teaching hospital. The direct costs are related to the supervision of the patient care activities of the students. The indirect costs are related to the decrease in productivity as a consequence of the presence of a teaching program in the institutions (10, 11, 12). Both contribute to an increase in the operating costs of a teaching hospital as compared to those institutions without teaching programs.

In a more competitive market, community hospitals and ambulatory care institutions may discontinue their affiliations with medical schools. This would pose serious problems because their resources are essential to meet the clinical clerkship requirements of larger classes and to provide clinical experiences in primary care. A loss of affiliated hospitals would place a greater burden on the major teaching hospitals which might not have enough patients to meet the needs. In addition, students in all hospitals might be pressured to provide more service at the expense of their educational experiences.

Price competition may jeopardize the substantial contributions of volunteer faculty to medical education as pressure increases to maximize physician productivity. The volunteer faculty may reluctantly find that teaching time compromises efforts to be competitive. It would be unfortunate if competition did not provide incentives for voluntary physicians to continue their important role in clinical medical education.

Graduate Medical Education

There are approximately 65,000 residents presently in training. Total 1978-79 expenditures for housestaff stipends and benefits were about $1.02 billion (13). About 80 percent of these costs, which average about $2.4 million in COTH member hospitals, are funded from patient care revenues (14). In addition, there are direct costs of graduate medical education related to physician supervision, support staff, and educational space and equipment. There are also indirect costs and reduced productivity associated with residency training.

The direct costs of graduate medical education, which are larger and easier to quantify than those for undergraduate clinical training, will be carefully scrutinized under competition. Third parties, HMOs and others contracting with hospitals for medical services may not wish to share in these costs and thus may not permit subscribers to use teaching hospitals except for complex care not available elsewhere. Based on evidence from the past, it also appears that HMOs and other alternative delivery systems will be reluctant to participate in graduate medical education.

In a more competitive system, hospitals may have to reconsider the number and types of educational programs they sponsor. Since the number of entering residency positions is only slightly larger than the number of students graduating from U.S. medical schools, any substantial reduction would pose serious problems for graduate medical education which is an essential component in the education and training of a physician for independent practice. The high quality of our medical care would be compromised. In addition, the important contributions that residents make in the education of undergraduate medical students would be diminished.

Proponents of price competition must give more thought to the impact of their proposals on all levels of the continuum of medical education and training if we are to provide the next generation of well-trained physicians.

Allied Health Sciences Education

In addition to participation in physician training, teaching hospitals are the setting for a growing number of allied health education programs. This includes not only an increasing number of advanced nursing degree programs, but a large number of technical and specialist programs required to meet the manpower needs of the health care system. Although the total costs associated with these programs are difficult to estimate, many programs could not be sustained without hospital involvement. If educating allied health professionals adds to costs, what incentives will exist under price competition to continue support for these programs? Which hospitals will discontinue participation? Will we be able to maintain a socially-desirable mix of health professionals, or will profit-incentives skew demand for certain types of professionals in an inappropriate direction?

Applications of Research

As biomedical research advances medical knowledge, teaching hospitals have been the settings where this knowledge is translated into medical practice and disseminated to physicians and other health care institutions. The initial applications of new treatment modalities are unquestionably expensive, but can result in cost effective treatment in time. Considerable attention has been given to the proliferation and overutilization of some types of new technology. Perhaps not enough attention has been given to the contributions academic medical centers have made to vastly improving patient outcomes, using relatively cheaper, effective medical treatments. Some noteworthy examples include:

- Kidney transplantation which has proven to be more effective and efficacious than chronic dialysis for treating many forms of end-stage kidney disease.
- Development of chemotherapy for treatment of leukemia, lymphomas and other cancers.
- Bone marrow transplantation for treatment of aplastic anemia and myelogenous leukemia.
- Evolution of heart surgery for treatment of congenital heart disease, coronary blood vessel disease and conductive defects.
- Development of major trauma centers.

- Development of neonatal intensive care units.
- Development of antimicrobial vaccines such as pneumococcal vaccines.
- Development of joint prosthesis.

These new treatments are accompanied by large developmental costs associated not only with the specific program but with the total environment required to support evaluation of new treatment protocols. Initial applications are often not cost effective nor do they always result in improved patient outcomes. The financial incentives created by price competition will encourage use of only presently available treatments and not promote development and testing of new methods of treatment. This environment is not likely to be one in which clinical researchers will feel welcome and be encouraged to flourish.

Tertiary Care and Case Mix

Related to applications of research is the provision of regional, tertiary care services to seriously ill patients. Historically, these services have been provided by teaching hospitals. Present pricing and cost allocation policies in teaching hospitals often result in having the reimbursement for primary and secondary care subsidize tertiary services. Under price competition, teaching hospitals would have to modify these policies. Tertiary services would have to be priced significantly higher while routine care would have to be priced substantially lower.

With changes in pricing policies, teaching hospitals may be able to compete well in providing tertiary services because they have provided a leadership role in this area for many years. The presence of full-time, faculty physicians representing all specialties and supported by housestaff helps to ensure high quality care. Teaching hospitals traditionally are sources of the best, most advanced treatment available, and consumers are likely to demand access to these services even if the price is high.

Competing in secondary and primary care may be more difficult for teaching hospitals. The problem may be most difficult for urban teaching hospitals that have a large number of indigent patients having multiple, chronic problems, which may not require tertiary services but do demand more intense nursing services and more prolonged support services such as social service and discharge placement efforts. Even if these patients were provided a "voucher" to participate in a prepaid, capitation payment plan, many health plans would likely try to avoid these patients because of their generally more complicated health and social problems.

Caution should be used in developing policies under price competition that would severely limit the teaching hospital's role in primary and secondary care. Steps should be taken to ensure that phasing out routine levels of care would not also mean phasing out access to care for some patient populations. In addition, educational programs cannot be conducted in the absence of primary and secondary care, and it is unreasonable and impractical to believe that an added number of community hospitals would assume these educational responsibilities in a price competitive market. Furthermore the aggregation of intensely ill patients to the exclusion of a reasonable number of the less ill may make for such a stressful hospital work environment that recruiting and retaining staff become a problem.

Charity Care

Many teaching hospitals, particularly in urban areas, provide large amounts of service to the poor and near-poor of their communities. This care includes not only inpatient services, but ambulatory care on a large scale. Economically disadvantaged patients often pay no charge or a charge that is below cost. Hospitals remain financially viable by pricing services to full-paying charge patients at levels sufficient to subsidize the charity care. For hospitals to be price competitive, this cross subsidization would be impossible to maintain, and hospitals might be unable or reluctant to continue any extensive commitment to treating patients who are unable to pay.

If vouchers are provided to the indigent population, a portion of the uncompensated care problem would be lessened. However, many illegal aliens and others who for some reason are ineligible to receive a voucher would still have no source of payment for medical services. Furthermore, even if the indigent are provided vouchers, many may select low option plans with high out-of-pocket expenses they will be unable to meet when care is required. The combination of uninsured and underinsured patients would encourage a move away from a one class system of care back to a two class system. Market forces and price competition can only sharpen the incentives to provide more adequate services to those for whom payment is assured.

Ambulatory Care

Per visit costs of hospital-based ambulatory care and other ambulatory care settings participating in medical education are often significantly higher than the costs of office visits of community physicians. Many reasons for the differences are typically cited. Visits to teaching hospital clinics are often referrals with a wide range of complex problems that are costly to treat. Productivity is lowered due to the presence of physicians in training. Many states and the Federal government have helped to offset these costs by providing grants for primary care training. For hospital-based ambulatory care, additional costs are incurred because of the cost reimbursement allocation guidelines which burden outpatient departments with overhead costs not present in freestanding clinics.

Most of the literature suggests that the presence of education in ambulatory or outpatient departments makes it very difficult for them to be self-supporting (9, 10, 11, 14). Rarely are fees or costs competitive with fees for office-based visits. Some will argue, however, that free-standing ambulatory care centers with educational programs can be productive, and in cases where the center is a source of inpatient business, the satellite can lead to increases in hospital inpatient revenue. Thus, the evidence is inconclusive, but it is clear that given current operations, some ambulatory care programs and primary care training sponsored by teaching hospitals and medical schools may suffer with an increased effect of market forces. However, it is imperative that teaching hospitals examine the organization and efficiency of their outpatient services to determine what it would take to succeed in a price competitive market. To the extent that productivity losses from education and indigent care are the problems, special consideration could be sought, but any other reasons for special treatment may be increasingly difficult to support.

Faculty Practice Plans

Medical schools are increasingly dependent on fees generated by the clinical service of the faculty. Faculty practice plan revenue now constitutes over 14 percent of all medical school revenue, up from 4 percent in 1967-68. Under price competition, health plans are not likely to evaluate physician fees for professional services in isolation from hospital prices. There will be an increased effort to price the package of hospital and medical services together rather than independently. Because the costs of hospital services in teaching settings are typically higher, pressures may be placed on physicians in teaching hospitals to reduce their fees so the package of services will be price competitive, or physicians may choose to admit their patients in hospitals where costs are lower. Either could lead to a decrease in patient volume and faculty practice plan revenue. This situation could also create incentives for physicians and dentists to leave academia for private practice or demand a higher proportion of the practice plan revenue. Either prospect would diminish medical school revenue and jeopardize educational programs.

Separate Funding of Unique Costs

Two generalizations may be drawn from the discussion of the above eight issues. First, teaching hospitals have a wide variety of products, many of which are produced simultaneously and involve more than the delivery of inpatient hospital care. Second, all of these multiple responsibilities and the costs associated with them are related and interdependent.

Academicians, legislators, and third parties may be willing to acknowledge that teaching hospitals have made important societal contributions to the education of future physicians and the advancement of medical practice, and that these contributions do not fit easily into the price competition model. The commonly offered solution is to identify and separately fund these activities on their own merits. In effect, this approach argues for centralization and regulation of decisions for these activities, but decentralization, through price influenced market mechanism of all other decisions relating to patient care services. The provision in the Gephardt/Stockman bill authorizing grants "for not more than" 70 percent of the direct cost of graduate medical education is one example of how legislators might try to resolve this issue. Efforts to carve out and separately fund unique, socially desirable attributes of teaching hospitals should recognize potentially negative impacts of this approach:

- Separate funding of graduate medical education may limit the ability of medical schools and teaching hospitals to make local decisions about their residency programs. As Paul Ellwood has stated, "It's clear that whoever bears the cost of medical education will increasingly want to specify the numbers, types, and geographic distribution of those whose education is being subsidized." (2)
- Federal support for graduate medical education may be subject to the budget and appropriations process which could make such a fund vulnerable to any major efforts to cut federal spending. The level of funding would have to be renegotiated annually before a changing cast of decision-makers who would have varying perspectives and knowledge about graduate medical education financing.
- The administration of the fund could be extremely complex. How would the necessary funds be collected? How would those responsible for distributing the funds decide which hospitals would get support and what that level of support should be? Even if total funding is adequate, wouldn't individual hospitals be vulnerable to significant yearly fluctuations?

Numerous studies have attempted to separate the costs associated with education, tertiary care services, and research-related costs. No consistent estimates of these costs are available because there is no calculus that permits the allocation of costs for joint products simultaneously produced. Further study should be encouraged, but it should be recognized that the marginal costs of one activity cannot be evaluated from a policy standpoint without considering its relationship to other teaching hospital functions. A policy that would decrease the size of a residency program may also mean a decrease in the scope of services available. A policy that would increase emphasis on primary care education cannot be done without access to patients with routine problems. A policy that advocates a high priority to develop advances in medical care necessitates not simply funds, but clinical fellows, faculty, patients, and other institutional resources. Any attempts to segment the unique characteristics of academic medical centers into measurable units run the risk of ignoring the fact that their contributions are the products of many inter-related programs, which together provide the environment and resources required for teaching future health manpower and advancing medical knowledge and practice.

SUMMARY

Creative solutions to problems in medical services are welcome, and advocates of price competition have made a major contribution to stimulating a re-evaluation of the status quo. Any legislation that would bring about reforms as broad as those advocated by price competition merit careful study. This document has reviewed the potential impacts of price competition on teaching hospitals. It is not a policy statement, but a document intended to stimulate further discussion of price competition which will result in constructive, sound recommendations to those responsible for charting the future course of the health care system.

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Chairman JACOBS. Thank you for your testimony.

Father.

STATEMENT OF T. BYRON COLLINS, S.J., SPECIAL ASSISTANT TO THE PRESIDENT FOR FEDERAL RELATIONS, GEORGETOWN UNIVERSITY, ACCOMPANIED BY MARY S. ALBERT, COORDINATOR OF INTERGOVERNMENTAL RELATIONS, GEORGETOWN UNIVERSITY MEDICAL CENTER

Father COLLINS. Thank you, Mr. Chairman. I will be very brief.

Georgetown University Medical Center has four components and we will comment from that point of view.

We have a school of nursing, school of dentistry, school of medicine and a teaching hospital.

One, we request that whatever competitive legislation which you endorse, recognize the extended role that nursing has.

Two, dental benefits should be included in the minimum benefit package which qualifies for tax exemption.

Three, reiterate that a research mission of a teaching hospital and its health professions schools should be recognized.

Four, the educational and training activities should also be recognized as an essential part of patient care. Therefore, their costs should be built into the system, and not left to grants and contracts which would only fund part of the costs.

Five, that costs of patient care to persons who are not fully covered by health insurance cannot be absorbed by the teaching hospitals. We have already absorbed some under the medicare-medicaid provisions. If we are to continue our functions, we must have these recognized as costs.

Six and last, the teaching hospital offers a full range of tertiary care which should be fully reimbursed and protected from institutions which offer very selected patient care services. We cannot compete with those because to offer a full range of services is not our function.

I would like to end by saying that hospital care is like a fabric. The fabric has components to it. As you examine the threads which sustain the entire cloth, you find your teaching hospitals.

Competition that would destroy teaching hospitals is going to have a very adverse effect on the rest of the cloth. We have some ideas that, perhaps, if the committee were interested, we could submit for the record.

Thank you.

[The prepared statement follows:]

STATEMENT OF T. BYRON COLLINS, S.J.

Mr. Chairman and members of the Committee, I am T. Byron Collins, S.J., Special Assistant to the President of Georgetown University. With me is Mary S. Albert, Assistant to the Chancellor of the Georgetown University Medical Center. We appreciate the opportunity to testify before you today on proposals to stimulate competition in the financing and delivery of health care.

At the outset we wish to indicate our support of legislative proposals incorporating competitive strategies which will assist in assuring an acceptable level of high quality health care to all citizens within a system which builds incentives for cost containment. It is clearly impossible to assure all Americans of accessible and acceptable health care unless the consumer, provider and insurer of health care share more directly in the decisions that generate health service delivery as the legislation you are considering seeks to accomplish.

As a Medical Center with a university teaching hospital and three health professions schools (Nursing, Dentistry and Medicine) our interests in this legislation is considerable. Our concerns are probably very similar to those of the academic medical centers located in every committee member's state. We wish at this time to underscore the importance of six issues relating to competitive strategies.

1. *Competitive legislation must recognize the extended role of nursing.*—Our School of Nursing which has both baccalaureate and graduate programs in nursing is committed to training nursing professionals who have the education and skills to assume the broader roles in nursing that have developed in the past decade. We believe that these broader roles should be explicitly recognized in legislation dealing with the reimbursement of health services.

2. *Dental benefits should be included in the minimum benefit package which qualifies for tax exemption.*—Our School of Dentistry seeks recognition of the importance of dental care, particularly for the age extremes of our population: the young and the increasing proportion of the aged. A minimum level of dental care for these population groups should be a required benefit in health insurance policies.

3. *The research mission of the teaching hospital and its health professional schools must not be jeopardized.*—Teaching hospitals and academic medical centers in this country are nearly always in the forefront of scientific advances in medicine, dentistry and nursing because research is performed in association with them. As research knowledge is applied to clinical practice, the teaching centers incur major expenses. These institutions need realistic mechanisms for recapture of these costs.

4. *Educational and training activites must be reimbursed.*—The delivery of health care has traditionally been intermingled with biomedical research and the training of health professions and it is very difficult to break down the costs of these components. The Medicare ratio of house staff to hospital beds represents an excellent effort to identify educational costs. Although the exact ratio at which a teaching hopital can be classified a major teaching institution may be debated, it is clear that for many university teaching hospitals, such as ours, there is a significant proportion of house staff to hospital beds (in our case 150:501, or 1:3) which identifies that institution as having a major commitment to training. Inevitably, there is a higher cost of services which results from this intensive personnel ratio, and from the high cost of technology and technologists at the hospital which not only provide patient care, but also teach health professionals the state of the art. Without some adjustment built into the system, and not left to grant and contracts which fund only part of the costs, the university teaching hospitals may be adversely affected, resulting in an unacceptable decline in health professions education and biomedical research, as well as in patient care provided in these important tertiary care institutions.

5. *Costs of patient care to persons who are not fully covered by health insurance cannot be absorbed by the hospitals; their costs must be reimbursed.*—Even the best health insurance schemes will result in a portion of people who are not adequately covered at all times: whose benefits do not cover their expenses, whose coverage is insufficient. It is imperative that providers not be asked to absorb these costs. Already, for many university teaching hospitals, the Medicare and Medicaid reimbursement limitations do not cover the full costs incurred. As competitive strategies establish marketplace interactions, these costs cannot be passed on. This is an especially difficult problem for university teaching hospitals which are usually in larger urban settings and generate higher routine costs due to the higher costs of goods and services, higher wages, and greater personnel turnover. A health policy based on competitive strategies must recognize that university teaching hospitals will not be able to continue absorbing these costs.

6. *The teaching hospital, which offers a full range of tertiary care must be fully reimbursed and protected from other providers which choose to offer selected high revenue health care services.*—Medical Centers must continue their responsibilities in training health professionals, pursuing biomedical research, and offering referral tertiary care. The resultant range of patient care is frequently high cost, with low net revenue, and places the institution in an uncompetitive position in relation to non-teaching community hospitals which can opt for programs with higher revenue opportunities. Strategies which create this set of circumstances would not be in the best interests of our medical system.

Mr. Chairman and members of the committee, the bills you are considering for the most part involve health insurance programs purchased for employees by their employers which will be eligible for continued tax exemption; ways of extending this insurance coverage to other segments of the population; and ways of bringing the individual consumer more into the decision-making process in health care by increased cost-sharing. These bills do NOT deal with the specific arrangements which will evolve between insurer, consumer and provider of health care. Clearly the intent of the legislation is that the provider of the best services at the cheapest cost will be selected. We have no argument with this general premise.

We do, however, urge you to consider that the teaching hospitals and schools of medicine, dentistry and nursing are the bulwarks for the future high quality of American medical care. The delivery of medical care services is of vital concern not only to the communities they serve, but to the education of future physicians, dentists, nurses and other allied health professionals.

We submit that academic centers, with their multiple mission of educating health professionls and performing biomedical reaserch while delivering significant patient care, cannot compete on the basis of price. Legislation to stimulate competition in the financing and delivery of health care can result in unwanted and unexpected consequences. We therefore urge the committee to specifically recognize the unique quality and method of delivering care which is fundamental to the academic health science center.

Chairman Jacobs. Thank you, Father. Two minutes, 14 seconds, you are ahead.

Will we have testimony from ~~Ms.~~ Albert?

Father Collins. No, she is the expert.

Chairman Jacobs. Fine.

Mr. Gradison?

Mr. Gradison. No questions.

Chairman Jacobs. Mr. Rangel.

Mr. Rangel. I will put myself on that time limit. I wonder whether or not it would be more consistent with the administration's approach if we took teaching hospitals for what they are, extensions of schools, and removed Federal subsidy from medicaid and medicare reimbursement for health services, and offered a direct subsidy for health training, or training doctors.

You are talking about schools. Perhaps you could answer that.

Mr. Frederick. The subsidy for education in our hospitals is a complex issue. There are certain expenses that are direct and you can put your hands on very quickly, namely, the stipends for residents in the graduate portion of the faculty components.

For example, in our hospital, we have 100 full-time physicians on our payroll and the proportion of their time that is involved in teaching, as well as research and patient care, is somewhat difficult to sort out. That is a possibility.

Of more concern to me, in particular, is the fact that these teaching hospitals, for the most part, are located in the inner city and we have a tremendous societal responsibility.

Mr. Rangel. Maybe if you separated the service that you are providing to the inner cities from the service you are providing to your student body, we might get a clearer understanding of what the Federal Government should be involved in.

As I understand the relationship, it is a little fuzzy. Those in the inner city that can't get any other type of medical care are dependent on the teaching schools for what health care they receive.

By the same token, when we are dealing with the Federal obligation to the school, we sometimes don't give it directly. We give it through reimbursement rates, so we don't really know.

It is a fuzzy, complicated situation. I would hope that your association might try to separate it so that poor people will not have to depend on the good graces of teaching schools, for health care. That is not right; that is not American.

As relates to Georgetown, Father, is the church removed from the hospital?

Father COLLINS. Yes, it is. The university itself lives or dies by its own financial resources.

Mr. RANGEL. I see. I see a lot of Jewish and Catholic and Protestant hospitals that have testified at various committees in the Congress. I don't find too much spiritual about the problems that they are facing. It is always the balance sheet. They are all nonprofit, but if we get a couple more Federal dollars out there, they could do a better job for everybody.

True, many of them are located in poorer communities. And like other public and private hospitals that find these patients without adequate coverage, they testify like nonsecular hospitals.

Father COLLINS. That is the precise problem, I think at all teaching hospitals, we echo our friend from Chicago. Mr. Gephardt had a proposal in his bill of 50 percent of the bad debts, which is your charity.

A teaching hospital, by its nature, aims for a large proportion of its patients from the charity group. That is by function of taking care of the poor, also, they are very willing patients to go through the experience of having young men and women learn together with them under the supervision of experts, their medical problems.

Mr. RANGEL. That is my problem, Father.

Father COLLINS. That costs a great deal of money.

Mr. RANGEL. Well, this is the taxwriting committee. So we have a variety of tax problems that come before us. Some of them deal with charitable giving.

It is hard for us to tell how the teaching colleges manage unless they tell us.

Are you managing so we can encourage people to make further contributions? Are you managing because of the Federal reimbursement system?

Are you in trouble because the Congress is not doing enough to take care of those people who can't care for themselves? I will just set aside for some other meeting or hearing where the churches are and where the synagogs are as to why, from a spiritual point of view, these people don't have the proper coverage.

It should be embarrassing for any religious sponsored hospital to have to close its doors, as they are forced to do, because the patient can't pay.

It just seems—and I don't mean to single out Georgetown—but I have been down here for 10 years, and I just don't hear the church, those that sponsor hospitals, speaking out as loudly about the need for greater coverage for the poor as they do about the fiscal problems that the hospitals are having.

It just seems to me that it should be two voices: one to deal with the real fiscal problems that patients and professional people are having at hospitals that service everybody.

And another loud voice that says, we shouldn't be placed in this situation; there should be coverage for everyone that needs our services.

I just can't find any testimony, even before I came here, advocating this. Maybe this is not the proper forum, but I don't even hear it in my church back home.

Father COLLINS. That is one of the reasons I am here.

Mr. **Rangel**. Well, you separated yourself from the church when I asked the question.

Father **Collins**. No, I—I thought you were saying, does the church give financial aid. Was that the thrust of your argument?

Mr. **Rangel**. I was really trying to find out whether it was a church sponsored hospital.

Father **Collins**. That it is.

Mr. **Rangel**. You said it was a university sponsored hospital.

Father **Collins**. My answer missed your thrust. I thought you were saying, does the Catholic Church and the Jesuit Order provide regularly funds for the support of——

Mr. **Rangel**. No that would be the church's business. No; my question is, When I go into that hospital, could I feel——

Father **Collins**. That you are in a Catholic hospital?

Mr. **Rangel**. Exactly.

Father **Collins**. You have chaplain, churches——

Mr. **Rangel**. You can strike from the record all the rest of my questions because if I thought I was in a Catholic hospital, then I would want Jesus to be felt, not only in that hospital, but when you, as the hospital's spokesman, testify as to what is moral.

The Catholic hospitals and the Jewish hospitals and the Protestant hospitals have to come here to see how we can manipulate the system for them to survive. And that is what we are doing, reviewing hospital reimbursement, not because it is fair and equitable or even right, but because it is necessary.

But if we shift and don't take care of your fiscal needs, you are out of business.

Father **Collins**. Yes.

Mr. **Rangel**. And that is sad. But that's our business.

Father **Collins**. We will do our best in order to stay in business.

Mr. **Rangel**. I don't blame you for doing it, but I would hope that somewhere along the line, some people who are not directly in the hospital business can say, if you took better care of the Nation's poor, you would allow us to do a better job without having to come and embarrass ourselves by begging the Congress for what we believe is ours.

Thank you, Father. Remember me in your prayers because I am certain I will have to go to confession after my line of questioning.

Father **Collins**. I am glad you clarified that. Georgetown stands as a Catholic hospital, a Catholic medical center, and that is the reason for its existence, and because of that, we will stay in existence.

Mr. **Rangel**. Thank you.

Mr. **Frederick**. Just one comment on that subject. Our particular hospital was a free hospital up until World War II. I arrived there in 1974. The hospital operated in a deficit position. I looked back 25 years to see what contributions that hospital was making to society and found that in those 25 years, they had invested $38 million in charity care.

One of the objectives was to get that hospital in the black so that it could survive and have a future and continue to make its contributions to society, both in terms of care and in terms of producing manpower for the future.

We have been able to accomplish that, and a big part of it comes from the fact that we, through our efforts, raise funds in the community to support this endeavor.

We think that is a very important role that we play, and we will be celebrating our 100th birthday next year and we expect to be around long beyond that.

Those of us who are there at this time, I think the concern we have is that in order to shift from the burdens that we have and with the multiple roles of teaching and research, as well as care, and so forth, we want to be able to compete.

I think some of the sorting out of what the costs are for these various missions is important. It is something we have to do, or we will not survive.

Mr. RANGEL. I guess what I am talking about is really political, and that is that the high cost that we have is because it is believed, and it may be so, that there is excessive health care for some and not enough health care for others.

And so, as a layman, I would believe that hospitals are providing services that are needed and being paid for by working out bookkeeping arrangements.

Doctors are providing surgery that is not needed, and services are located in the highest pay modality as opposed to most efficient.

I don't expect any more from the American Medical Association, or American Health Association, they are professional and keep up their income.

But I do believe that a national university or a church, while it is in business, can point out that there could have been a higher standard of delivery of care without the Federal Government being involved, and asking for competition where the consumer now has to shop for the best possible package.

It should be society that dictates that you are going to offer the best you can and the government will see that the poor and others get some type of method so that they can afford to get the best.

But now you are saying the free marketplace is going to control the conduct of the hospital people and the doctors, I think.

You know, this is OK for me because I am a politician. But it should be sad for the church and sad for the university systems—who I like to believe are independent from the AMA and the AHA—in terms of raising moral standards much higher than we raise them in the Congress.

Mr. FREDERICK. There are differences of opinion there, as you have heard.

Mr. RANGEL. I know, but I am not going to get further in trouble.

Chairman JACOBS. I recognize Mr. Gephardt.

Mr. GEPHARDT. Two quick questions: One, I would like to ask if you don't believe that teaching hospitals would and could have a very marketable commodity in plans in a competitive system in that they would be the hospital's tough cases would be referred to, the tertiary care would be given there? And that while you can't lay off all of your costs, that the service you have to offer is something that would be sought after and could be a very integral part of competitive plans?

Mr. **Frederick**. No question. I think that that is where much of the tertiary care is lodged, and because of high costs of providing the resource to carry that out and to advance it, I think that most of your community-oriented hospitals will not opt for that. Therefore, we should be able to compete very well there. I think Americans look for quality and will continue to seek it, particularly as it relates to their health, of themselves and their families.

So I think in that area, as I mentioned earlier in my testimony, I think teaching hospitals can compete very well there. I guess the problem I am concerned with at the moment is the change that will have to take place in the way we deliver care that is involved in the teaching environment, particularly the outpatient side.

We are just going through that now in Illinois with the cutbacks in medicaid. It is obvious that we are stuck there with this tremendous societal responsibility, and we are going to be reimbursed less and I think that is a trend that will continue as we get into the competitive market.

How we organize to be able to achieve the teaching objective, as well as the service objective, is going to require some change on our part, and on the part of our faculties.

Outpatient and routine care is a big part of our business. We cannot survive on tertiary care alone, both from the standpoint of the cost, and from the standpoint of carrying out an effective teaching program because I don't think we want our future doctors to only be concerned with the tertiary care.

I think we need doctors who can be trained and see proper methods of routine kinds of care.

Mr. **Gephardt**. Let me just say two things. Let's not, I hope we don't confuse competition with diminished resources going to medicaid and medicare. Two different things.

And I certainly don't advocate the way we are going at cutting down medicaid and medicare by putting caps on or doing things that have been suggested in the past.

That really does complicate your problem. Competition, I think, should be separated from that whole concept and problem. In fact, I believe if we can get to competition as I see it for medicare and medicaid, we could make it a lot easier for you to operate with that population that uses those programs.

I do think there is a teaching and research component that we have got to figure out how to pay for in world competition.

My frustration has been in trying to arrive at how we separate out those costs. I believe some of your colleagues believe it can be done, are willing to try to figure out how they can do it.

Others either don't think it can be done or think it can, but don't want to do it.

Somehow, we have to figure out how to do it. I just wonder if you feel optimistic that that can be accomplished.

Unless we can figure out what it is, there is no reasonable way to figure out how to pay for it.

Mr. **Frederick**. I personally feel an attempt should be made and I think we can find a way.

Mr. **Gephardt**. I certainly hope so.

Thank you, Mr. Chairman.

Chairman **Jacobs**. Mr. Gradison.

Mr. **Gradison**. Thank you, Mr. Chairman.

Mr. Frederick, I don't want to get too off the subject. But if by some action, whatever is is, tomorrow, there were a means of payment for medical bills for everybody in our society, wouldn't the institutions that would have one of the hardest times adjusting be teaching hospitals?

That is, wouldn't there be new competition then for people reaching out aggressively to provide medical care and hospital care for the poor because the poor wouldn't have the options that are available to them today?

My sense in our community is that as these payments mechanisms increase, those who in the past would almost automatically go to our public institutions, the elderly poor being an example, are much more broadly distributed now among hospitals throughout metropolitan area, simply because they have a means of payment which they didn't have before.

I wonder if you would comment on that general proposition.

Mr. **Frederick**. I think if everyone had the capacity to pay for the care that they seek, that there would be some adjustments in our system.

I think that the people who are being served by the public hospitals would probably opt to go to other hospitals if they had a choice and there was no penalty to them in terms of their ability to pay. In our situation, for example, I think what you find is that a lot of the seriously ill children happen to fall in the lower economic spectrum. I guess the way the system works today many of those would be in our public institutions. They happen to be in our institution because we have the expertise to care for them and we have the ability to be able to subsidize their care.

Mr. **Rangel**. Excuse me, Mr. Gradison.

As to this competition, when people who live in poor communities receive a voucher, are they to assume they are now a full participant in the competition system? The line of questioning makes it appear as though they can get out of the poor neighborhood that they live in and get to the more affluent neighborhood where the more affluent hospitals are and waive some Federal guarantee and be treated like anybody else.

Mr. **Gradison**. I really wasn't referring to the pro-competition proposals at all. The point I was making, could apply to any system, national health insurance, whatever, that assures people a means of payment for the medical care which they require.

In our particular community, the Cincinnati General Hospital which traditionally has been the principal part of—though not the only hospital within our medical center but the principal teaching hospital—is located right next door to most or many of the private hospitals.

It isn't a matter of which ones serve the neighborhood. I appreciate that may be different in your community.

Mr. **Rangel**. I misunderstood the question.

Mr. **Gradison**. I have sensed from talking to people at our medical center a concern, if you will, about how they are going to be able to attract a variety of cases which they need for teaching purposes if the choice of where to go for medical care is really quite open, but by the availability of the means of payment.

This isn't an argument against providing the means of payment. I was just trying to take advantage of the knowledge of our witnesses on a subject which I acknowledge is not directly related to the subject of the hearing.

Father, would you care to comment on that?

Father COLLINS. Yes. I think they would all go to a teaching hospital. Georgetown University is in competition with two other teaching hospitals in the District. George Washington and Howard.

If you ask me, if you have the capability of going to the other private hospitals in the District, there are 29 in this area, we would be flooded, the teaching hospitals, if everybody knew that they had the same–would get the same coverage.

The reason is because of the kind of care you get. That is what we do like about Mr. Gephardt's bill, quality, we maintain teaching hospitals are the inner core of the quality of medical care.

Mr. GRADISON. If I may pursue that for just a moment.

Are staff—can doctors practice at our hospital whether or not the members of your teaching faculty and bring patients in there?

Father COLLINS. Yes.

Mr. GRADISON. Thank you.

Chairman JACOBS. The committee expresses its gratitude to the panel for its testimony and the interesting discussion that followed.

The next panel consists of representatives of the American Coalition of Citizens with Disabilities, Paralyzed Veterans of America and the Cystic Fibrosis Foundation.

Would those witnesses please come forward, identify yourselves and proceed in the order that you choose among yourselves.

Please proceed. Don't forget the big reward at the end of the day.

STATEMENT OF EARL KELLY, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. KELLY. Mr. Chairman and members of the subcommittee, on behalf of the members of the Paralyzed Veterans of America it is a privilege for me to speak today on possible changes in the delivery of health care services to Americans.

I am Earl Kelly, associate legislative director. I regret Mr. Powell could not appear.

PVA has approximiately 12,000 members, all of whom have experienced spinal cord injury or dysfunction; therefore, we have considerable experience in the health care needs of catastrophically disabled persons.

Our concern goes beyond veterans and includes adequate medical and health care for all catastrophically disabled individuals. Therefore, I will address matters pertinent to severely disabled Americans.

PVA recognizes that the hearing today is to investigate several legislative proposals aimed at increasing competition in the delivery of health care services.

The ultimate goal of these legislative proposals is to reduce the cost of health care, or at least to curtail the rapidly rising cost of such services. PVA, like the sponsors of these proposals, wants to see the cost of health and medical care contained or, if possible, reduced. We realize that the cost of care has risen at approximately twice the rate of other essential services and goods during the past few years.

While PVA welcomes efforts to reduce expenditures by individual citizens and by the Federal and State governments for health care, our overriding concern is that the availability of quality care must not be diminished in an effort to reduce expenditures.

Today, PVA will confine its remarks to H.R. 850, the proposed National Health Care Reform Act of 1981. This bill aims to "institute fundamental reforms in the health care delivery system, to assist all Americans in obtaining health care, and to restrain increases in the cost of health care."

Under the provisions of H.R. 850 the Federal Government would offer to the aged and disabled a voucher system for purchasing health care services. They would receive financial assistance to join health care plans, should they choose to receive care in this manner instead of from the existing medicare plan offered by the Federal Government through the social security program. Individuals presently receiving care through medicaid would receive vouchers with which to purchase care from health care plans, should the States of residence desire to provide for such a plan. Beginning January 1, 1988, each State could make the election, not the individuals covered, and a State may not revoke an election. [section 403.]

We recognize that individuals who are presently receiving care under medicare would be allowed to select whether to join health care plans or to continue in the receipt of care through the existing system. However, it is evident that one purpose of H.R. 850 is to reduce or abolish the Government's role as guarantor of health care services for disabled and elderly individuals.

One of PVA's greatest concerns with H.R. 850 is that many severely disabled persons will not be admitted to the proposed health care plans. While they could continue, at least for a while, to receive care under medicare or medicaid, these services would not be available should the procedures outlined in H.R. 850 be allowed to replace the existing medicare and medicaid systems.

Section 5 of the bill, "Definitions and Glossary of Terms," defines "Disabled Individual," and "Aged Individual": the bill fails to define "Medically High-Risk Individuals," leaving it to the Secretary of Health and Human Services to define them by regulation at a later date. Nonetheless, section 203, "Membership in Qualified Plans," states: "A plan may, with the approval of the Secretary, limit the number of medically high-risk individuals which the plan must accept for enrollment as members." The section goes on to state that when a plan desires to limit the number of high-risk individuals, "the plan shall apply to such individuals in the order of consideration of applications." High-risk persons who apply will not be admitted after the plan has determined that its quota for such individuals has been filled.

In the desire to remove Government involvement from the field of health care, H.R. 850 would leave many severely disabled and elderly Americans without adequate health and medical care. For example, section 201 of the bill gives the Secretary of Health and Human Services only 30 days in which to determine a given plan's eligibility as a provider. Should the Secretary, due to heavy work loads or the need for more extensive investigation, fail to approve the plan within this short time, it is automatically approved. Once a plan has been approved, or has received approval through the Secretary's default, there are even fewer controls on the plan. It can reduce the scope of health care services provided to members or can increase the out-of-pocket expenditures required of members of the plan and the Secretary has only "21 days after receipt of notification of such a change" in which to disqualify the plan. [Section 209.] In short, even if the Secretary is desirous of insuring that "medically high-risk individuals" are to be covered under a given plan at a reasonbale cost, there is a likelihood that the plan can safely exclude such persons.

Persons with serious preexisting conditions can be summarily dismissed as high-risk individuals. Or, if they are admitted as members of plans, they specifically can be denied coverage under the plan for their preexisting conditions.

There is also the problem that adequate plans will not even exist in certain areas of the country. Section 2 of the bill states that one of the major problems which H.R. 850 purports to rectify is that numerous persons are not able to obtain sufficient health care either because the necessary personnel and facilities are not located in their communities or because they do not have adequate financial resources to obtain such services, or both. The bill maintains that the lack of availability is one of the deficiencies of the existing system. Yet, section 5 states that individuals will be eligible to receive care only in their places of residence and an individual shall not be regarded as a resident of a place to which the individual has traveled solely for the purpose of receiving health care.

As noted above, PVA feels that many health care plans will deliberately exclude medically high-risk persons, a group not defined in H.R. 850, and it appears obvious that severely disabled persons would be defined as medically high-risk. Furthermore, as it appears in section 5, severely disabled persons would be confined to enrolling in plans which cover their geographic areas of residence, but the bill does not require that services needed by disabled persons would be included in these local plans.

More specifically, a great number of disabled persons reside in thinly settled regions of the Nation. There is a likelihood that a variety of plans will not exist in those regions. And, where a single plan exists, there is even a stronger probablity that it would not offer specialized care needed by these persons. It is a recognized fact that the smaller a health care system is, the less sophisticated are the services it can offer. Facilities offering sophisticated and specialized services are generally part of much larger systems or they extend their specialized services to persons from across large regions. Some, such as burn clinics, shock trauma centers, and spinal cord injury centers, extend initial treatment to persons from all over the Nation. The facilities which can provide appropriate continuing care, once these conditions have been stablized, are equally as specialized and are located in only select areas of the country. There are only 33 [combined VA and civilian] spinal cord injury centers located throughout the United States, and they are not geographically dispersed.

Under the existing national system, a severely disabled person can reside in the area of his choice, for whatever reason which dictates his residence there. Many, for example, live with family members who help them with their daily needs. However, when serious medical problems arise, they go for treatment at centers capable of dealing with their complex medical problems. Under the provisions of H.R. 850 there would probably be no appropriate care for them under their local plans and they would not be eligible to receive the needed care at distant facilities. Hence, the only conclusion is that they will either have to go without needed care or will receive it at distant facilities at additional cost to them and their families. It should be remembered that many such persons, because of their disabilities, do not have the resources to offset these extra medical costs, and their families are too often already strapped financially.

Disabilities can be financially devastating, but it has been the Government's policy that disabled persons will receive adequate medical care. The system of care proposed in H.R. 850 does not reflect this policy of humanely insuring that catastrophically disabled presons will receive medical care. Under the proposal, where a disabled person is a member but the plan cannot offer needed services, the plan is virtually excused from helping that person locate adequate care. Section 207 of H.R. 850 states:

> (a) Rights of members to refuse services.
>
> (1) Right.—The plan agrees to permit any member for any reason whatsoever to refuse to be provided a health care service by a person designated by the plan to provide that service.
>
> (2) Nonliability of Plan.—If a member of the plan refuses a service under paragraph (1) and the plan is not reasonably able to arrange for another acceptable person to provide the service, the plan shall not be responsible for failure of the member to be provided the service.

Section 207 appears to be designed to allow members some flexibility in selecting the practitioner who provides treatment, and it especially protects the health care plan from tort liability. In the case of disabled members, this provision is especially alarming because the plan need not provide for the transfer of the individual to another facility, at the expense of the plan.

The disabled person is likely, for good reason, to refuse even nonspecialized care by affiliates of the plan to which he was subscribed. An example of when a subscribing member of a health care plan may wisely forego care arises in the case of a person who has experienced spinal cord injury or dysfunction.

This person is very susceptible to decubitus ulcers, which are sores caused by pressure being applied too continuously on the buttocks or lower extremities. Once such sores develop, they are life-threatening, often resulting in infections leading to blood poisoning.

Decubitus ulcers can originate from lying in bed without being turned, or from heavy objects or constrictive casts or bandages being placed on the lower extremities.

Catastrophically disabled members of a health care plan, it is expected, will allow routine medical matters to go unattended because of the fear of greater harm while undergoing treatment.

There are numerous cases of health care problems such as decubitus ulcers arising while paralyzed patients are in hospitals, where inexperienced personnel do not understand the needs of such patients. Under the provisions of section 207, however, the plan is under only a reasonable obligation to help its disabled members, and it appears that the plan gets to define reasonable effort and that this effort need not be exerted beyond finding a provider who is affiliated with the plan.

Thus far, I have dealt largely with the problems the individual disabled citizen will face when he seeks to receive health care in his geographical area of residence. However, H.R. 850 presents even larger problems for elderly and disabled persons, and these problems warrant mentioning. Section 104 of the bill outlines the payment procedure: the Secretary of Health and Human Services will make a direct health care contribution, in the form of a health care voucher, to each eligible individual who is aged or disabled. On or before September 1 of each year, which is before a plan year begins, the Secretary shall publish this amount in the Federal Register.

There are at least two inherent problems in this procedure. First, it can actually increase the cost of health care by informing plans in advance what they can charge. Second, it can induce the financially disadvantaged disabled person to convert his voucher into a cash allotment instead of subscribing for care. This is especially likely to happen when a person resides in an area where there is only a single health care plan and that plan has not met his medical needs during past experiences.

To continue with the financing method, the system of financing the proposed voucher system of health care delivery makes it probable that there will be a systemwide inadequacy of funding. Section 104(b)(2) explains how the Secretary is to determine the amount of voucher payments. He is to examine the amount of funds collected by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund during 1982. Both funds are established under the Social Security Act. From this amount he is to subtract payments made for medicare beneficiaries. It is PVA's understanding that he then is to divide this remaining amount by the total number of eligible beneficiaries, whether they have enrolled under plans as outlined in H.R. 850 or remained under medicare, and this constitutes the base payment which the Secretary will contribute for each eligible individual. It is PVA's observation that if this financing method is used there will be a lesser amount available for each eligible person because the remaining amount of money will be divided by the total number of persons eligible under the existing and the proposed systems.

Because the health care plans provided for under H.R. 850 would be financed with amounts remaining after payments have been made under medicare, PVA questions the possibility that the dual systems—that which exists now and that proposed by the bill—can operate simultaneously. Section 104(b) also indicates that the amount of Government contribution to be provided for health care has no relationship to the care which is needed. Instead of basing payments on the amounts beneficiaries actually will have to pay as members of health care plans.

> The Secretary shall increase or decrease each of the amounts so determined by the same percentage as the percentage increase or decrease in the GNP deflator from the second quarter of 1981 to the second quarter of the year before the plan year in question.

By definition the elderly and disabled are not members of the active work force but, under the provisions of H.R. 850, their health care will depend directly on the productivity of the work force, on international trade agreements, and on worldwide economic conditions. The GNP is even less reflective of increases in health care costs then is the traditionally used Consumer Price Index.

Persons now receiving care under medicaid would, as noted earlier, have little individual say in determining whether they will remain under the present system or will subscribe to health care plans, since the States will make irrevocable decisions for them. It is evident that many States will elect for these recipients to be treated under plans outlined in H.R. 850, because "the State will determine, in accordance with standards and procedures established by the Secretary, the eligibility for (and amount of) a health care contribution under this section for eligible individuals residing in the State." Section 105, there is great freedom here for the States to curtail expenditures for health care services for the needy.

PVA is very concerned that qualified plans will not offer a variety of services which are essential for elderly and disabled persons. Health care plans need not offer "examinations to determine or correct the refractive state of the eye or hearing examinations," "eyeglasses or hearing aids," "items and services related to mental or emotional illnesses or conditions," "treatment for chronic chemical dependency," or dental care "unless relating to injury or disease affecting the jaw." As a greater portion of Americans are becoming elderly, and as the number of disabled persons is increasing, this legislative proposal would do nothing to make life better for them by providing them with services and treatment which the medical arts can, today, make available. And, we read daily of the need for increased mental health services and alcohol and drug dependence treatment, but this bill would curtail even the present assistance given to those who seek such services.

Representative Claude Pepper provided some observations 2 years ago today, in the October 2, 1979, Congressional Record, which are worthy of repeating. Eleven percent of the American population is made up of persons over age 65 and 25 percent of all suicides in the United States are committed by members of this group. Also, 20 percent of all persons in the Nation who suffer from alcohol-related problems are in this same age group. It is known, also, that approximately 100 reversible conditions result in the same characteristics as does senility.

Mr. Chairman and members of the subcommittee, PVA feels that H.R. 850 is an attempt to address the problems faced by Americans as health care costs continue to rise. Yet, the provisions of H.R. 850, if implemented, are likely to cause inflationary results. First, the new system would be very fragmented, and the bill states:

> In considering the application of a plan to be located in an area, the Secretary shall not take into consideration the applications—or terms or conditions—of other plans for that area or adjoining areas. (Section 201.)

It would appear that in an effort to increase competition the provisions of the bill would actually encourage confusion.

Second, we feel that the system would be more subject to fraud than is the existing one, in that the existing system of care establishes stringent criteria which must be met before an applicant can receive health care assistance. Presently, an individual must be certified disabled or elderly or indigent in order to receive care through the centralized Federal and Federal/State programs. With the proposed local plans, it would be more difficult to insure that individuals subscribing for services meet appropriate eligibility requirements.

Finally, the fragmented system would create the need for additional bureaucracy. It would require a greater number of employees to administer Government assistance for members of these localized plans and to monitor these various plans. The bill provides for creation of the Health Benefits Assurance Corporation—to be established within the Department of the Treasury—to assist the Secretary of Health and Human Services in administering the program. And, in anticipation of problems which are likely to arise, the bill provides for arbitration boards and would establish a U.S. Health Court and a Health Court of Appeals. These would be largely duplicative of courts which already exist within the Social Security Administration.

At the outset of H.R. 850, it is written that:

> Congress finds that the majority of Americans are receiving health care of a quality unmatched elsewhere in the world but that the method by which health care currently is financed and delivered is inflationary and does not distribute quality care to all Americans.

PVA feels that the present system distributes quality care to more Americans than would the proposals contained in H.R. 850. PVA does agree that the present system has become inflationary in its effect; however, it has been one of the very reasons the quality of health care has improved, both for individuals and for certain areas of the Nation, because it has enabled more persons to afford health care and, consequently, to attract improved providers to less urban or less affluent areas.

While general health care services have improved nationwide, many areas still lack the experienced personnel and specialized facilities to care for the needs of severely disabled persons. The proposal, H.R. 850, would greatly restrict those persons from seeking specialized care in areas where it exists and would confine them to inappropriate local health care plans.

Mr. Chairman and members of the subcommittee, PVA appreciates your efforts at seeking to curtail rising health care costs. This particular legislative proposal deals extensively with health care contributions by employers on behalf of their workers, an area not analyzed in PVA's statement. Perhaps the legislative proposal is innovative in this area. However, the bill is threatening to disabled and elderly Americans and to Americans who cannot afford health care. It would repeal the Professional Standards Review Board but does not provide for substitute consumer evaluation of the plans to be offered. The only evaluation the disabled, elderly, or indigent user has is to change membership to another plan, which, as I have pointed out above, may be impossible. Furthermore, the bill states that health care institutions are largely relieved of their community service obligations and that they would not be required to deliver uncompensated care if half or more of the patient-days of such institutions were accounted for by members of qualified plans.

Financially borderline individuals who can care for most of their needs but not for emergency or extensive health care services will be induced to seek out public assistance as a way of life, not as an emergency measure.

PVA would strongly support measures aimed at reforming the existing health care finance system. However, we cannot support the abolition of the existing system or the replacement of it by a new system which reduces the availability of care for disabled Americans.

Thank you for your attention, and I will be glad to answer any questions that I can.

Chairman JACOBS. Mr. Kelly, I am sorry to say that you have taken exactly twice the 5 minutes. I hope other witnesses will be admonished by the rules of the committee because we are very short of time.

Mrs. Tulcin.

STATEMENT OF DORIS F. TULCIN, NATIONAL PRESIDENT, CYSTIC FIBROSIS FOUNDATION, ACCOMPANIED BY RICHARD E. VODRA, ASSOCIATE NATIONAL DIRECTOR FOR PLANNING AND PUBLIC POLICY

Mrs. TULCIN. Thank you, Mr. Chairman.

Mr. Chairman and members of the committee, my name is Doris Tulcin. I am the president of the Cystic Fibrosis Foundation and I am accompanied by Mr. Richard Vodra, our associate national director.

Over the past several years, there has been continuing debate over the need for legislation to increase competition in the health care industry. One voice has been conspicuously absent from this debate, however—that of the chronically ill individual who already faces difficulty in obtaining health insurance or employment, and whose difficulties may be seriously compounded by a competitive strategy in health care delivery. As president of the Cystic Fibrosis Foundation, I am here to offer what may be a different perspective, certainly an important one, to your discussions.

As the mother of a daughter with cystic fibrosis, and because of my involvement in the Cystic Fibrosis Foundation, I could give you any number of details about the medical, economic, and social problems that accompany the illness. But I would like to point out also that our problems are not unique. There are people with epilepsy, juvenile-onset diabetes, multiple sclerosis, and a number of other chronic diseases who face similar barriers to economic and social well-being. I speak specifically of cystic fibrosis because that is what I am most familiar with.

Cystic fibrosis is the most common genetic killer of young people in the United States; but, more important to the issue today, it requires a lifetime of extensive medical care, including daily respiratory therapy, constant use of prescription drugs, frequent visits to one of the 127 cystic fibrosis centers across the country and, for many patients, annual hospitalizations that last 2 weeks or more.

We estimate that proper care for someone with cystic fibrosis will cost, on the average, between $6,000 and $12,000 per year every year. We think the cost is a worthy one, not only because of the intrinsic value of human life, but also because with proper care many children who have cystic fibrosis can grow up and live as productive individuals into their twenties and even thirties, when only two decades ago, few cystic fibrosis patients survived to school age. We are hopeful that continued research will add many more years of life to those with cystic fibrosis as more clinical problems are conquered.

The high cost of cystic fibrosis does not stop with medical bills. Daily respiratory therapy is most often done by a child's parents, and is so time consuming that many mothers of cystic fibrosis patients cannot enter the work force to contribute to the family's income. The more fortunate patients, those who survive to adulthood, then must face employment discrimination and the prospect of only part-time jobs—barred from private health insurance because of their disease, but not sick enough to qualify for public support.

When we hear advocates of competition discuss their proposals, we hear a common theme: They all seek to make health care more expensive and less accessible for the individual, in the hope that individuals will choose to use less of it, or, at least, that the government can shift some of the costs of public programs to the beneficiaries of those programs. The competition proposals assume that choice is a primary determinant in the use of medical services. But people with cystic fibrosis do not choose to go to the doctor or the hospital. They were born with an inherited condition that requires their having constant medical care to stay alive.

We look with great alarm at the actions of Congress and the administration to reduce Government assistance for the families of cystic fibrosis patients, whether through medicaid caps or inadequate block grants. Over half of all cystic fibrosis patients are currently enrolled in one or another program of public assistance for their medical care, but still families face bankruptcies and the breakups that can result from trying to keep their children alive. Unfortunately, the voice of those families has not been elicited in the current debate, and we fear that the concerns of cystic fibrosis patients are no longer important to many who plan for our future.

We do not share the belief that our Nation spends too much for health care—at least with regard to chronic disease—and we have a number of specific concerns about the impact that the various competition proposals could have on people with cystic fibrosis.

The major issues, as we see them, can be grouped under three headings: will specialized care centers continue to be available? Will people who have chronic diseases have access to specialized care networks that provide comprehensive medical treatment? Over the last two decades, a network of 127 cystic fibrosis centers has been developed across the United States. These centers, accredited by our foundation and partially funded by us, are largely responsible for the tremendous strides in patient care that have led to major improvements in life expectancy. The proposals for making our health care system more cost conscious threaten the cystic fibrosis center network in two ways.

First, most of the centers are located in teaching hospitals. These hospitals use their general patient-care dollars to cross-subsidize many important efforts, including the education of health professionals, the translation of research into innovative patient care, and the maintenance of high-cost tertiary care facilities. In fact, while these functions are separable for discussion, they are inevitably linked in actual operations.

As explained in a March 1981 paper published by the Association of American Medical Colleges, reimbursement policies likely to result from competition legislation would most likely be inadequate to allow such higher cost institutions to continue providing their present range of services. While it is possible that direct funding could be increased for these activities, the recent appropriations record for various Public Health Service functions does not give cause for optimism. Many outpatient clinics and similar specialized services currently operate at a deficit, and we worry that without cross-subsidies or direct support, some institutions will be forced to discontinue their cystic fibrosis center operations, making this type of care unavailable to those who cannot travel to another center in a distant city.

The second problem is that competition would encourage insurers to place increased reliance on group practice, limited lists of available providers, and similar restrictions on a patient's freedom of choice. While we believe that cystic fibrosis patients will generally receive better care in a cystic fibrosis center than from a nonspecialist pediatrician or internist, we cannot deny that some cystic fibrosis patients are receiving care in a community setting, from physicians who presumably believe they are providing adequate care. If people are forced to receive their primary care from a limited list or an HMO because their employer chooses to offer only that type of plan, how will people with cystic fibrosis be protected from a refusal to certify them for outside care? Certainly the insurer will perceive, perhaps correctly, that going "outside" will add to the plan's costs; and doctors and hospitals may be discouraged from making referrals except when they see it as absolutely necessary.

To the extent that such restrictions prevail, the quality of care for people with diseases requiring comprehensive care over a long period of time will decline in the wake of new economic incentives. To avoid such a result, any mandated change in health care reimbursement must assure that specialized care centers can be funded at a level adequate to allow continued availability of their valuable services and continued improvement in the health of the patients they serve. Two, will the chronically ill have access to adequate health insurance?

The central problem faced by people with chronic illess is whether competition will even further reduce their ability to obtain health insurance.

The question posed has three aspects: The cost of insurance, its availability to those who are predictably high risks, and the benefit package to be provided. While these are all interrelated, we shall treat them individually for ease of discussion.

A. COST OF HEALTH INSURANCE

The proposed competition plans rely heavily on changes in the current tax laws to influence the individual consumer's spending and reduce utilization of medical services. The key concept is that consumers will be given greater opportunity to choose between comprehensive and modest insurance plans and, faced with less employer subsidy and the removal of tax reductions for insurance premiums, they will spend more carefully, selecting low-cost coverage, that is, minimum benefits, whenever possible. Logically, the need for more out-of-pocket expenditures would reduce the consumer's use of medical services. Another incentive for the purchase of low-cost plans is in the form of a cash rebate to employees who select a plan that costs less than their employer's designated contribution.

One major problem in this approach—that of "adverse selection"—has been widely recognized but not resolved. In effect, adverse selection means that in any group of people choosing between low-cost and high-cost plans, the younger, relatively more healthy members of the group will likely select the lower cost plan, and the older members as well as young ones with known health problems will gravitate to the high-cost plan because they can realistically expect to need more services. The long-range effect of such polarization is that, after rating their experience with the two groups, the insurance plans will be able to reduce premiums for the low-risk group but will have to raise them for the older, less healthy group, to a level well beyond what the difference in benefits alone would warrant.

Over time, the effects would be sizable financial gain for one group and a disproportionately high burden of expense for the other. People with cystic fibrosis would be severely affected by this situation. Given the current acute-care orientation of insurance coverage, people who need chronic care must expect to pay substantial out-of-pocket amounts in addition to higher insurance premiums.

The mechanisms at hand to reduce the disparity in costs—such as weighting of risks and continual manipulations of actuarial categories—could create a substantial administrative burden, and such rate adjustments may well create the need for continuing oversight and regulation, contrary to the competition proposals' intent to reduce Government restraints on health care delivery.

It would appear that the Gephardt-Stockman bill offers some hope for minimizing the effects of adverse selection. By allowing individuals to choose from all qualified plans in a geographic health care area rather than select from a small number of plans offered by an employer, the proposal would create a larger shared-risk pool and offer potential for a more heterogeneous mix of consumers in any one plan. The individual cost for this plan, however, could very well be prohibitive for a person who receives no employer contribution and is deemed ineligible for a Government health care voucher issued on the basis of age, disability, or poverty.

The young adult with cystic fibrosis who is able to work only part time or intermittently, but is not considered disabled, would be particularly vulnerable in this instance. The typical adult cystic fibrosis patient in 1980 had medical expenses of more than $6,000 per year and an income of less than $13,000.

What may be needed in this type of competitive proposal is a subscriber category—based on combined employment and medical histories—that recognizes the limited financial resources of persons who are not fully disabled but who have extraordinary medical expenses. In this way, people with chronic, episodic problems such as cystic fibrosis might obtain much needed financial assistance without sacrificing their status as working, contributing participants in the system.

B. AVAILABILITY OF INSURANCE COVERAGE

A national program for health care services that would provide all necessary health services to every individual is certainly beyond the scope of the competition proposals made to date. However, it is not unreasonable for the consumer in the health care marketplace to expect open access to the system.

It is important that all persons be eligible for participation in programs of health insurance coverage; and while the problems of many low-income people can be addressed through the use of medicare and medicaid, the person with health problems that label him "high-risk" but not "disabled" is in danger of being precluded.

Generally, an individual who is employed full time is able to enroll in whatever group insurance plan is offered by his or her employer, regardless of health status. However, a person with cystic fibrosis, whose chronic health problems may permit only half-time work or none at all, is constrained to seek individual insurance coverage, often with no success. According to a 1981 Cystic Fibrosis Foundation survey of adult cystic fibrosis patients, about half of the respondents who had tried to obtain private individual health insurance did not receive the coverage for which they applied.

The Hatch bill provides that carriers in each State must provide coverage to individuals who are not eligible for either group plans or government programs; premiums for such individuals may not exceed 125 percent of the cost for comparable group benefits in the same area. This proposal for carrier pooling would appear to make it possible for every person with cystic fibrosis to obtain some level of insurance coverage—at least equivalent to medicare—albeit at an inflated cost. Legislation to guarantee access to health insurance has been enacted in a number of States, including Minnesota, Connecticut, North Dakota, and Indiana. We believe this approach has considerable promise, and should be required if our Nation is to rely on private insurance rather than public assistance to finance health care for the medically needy.

The Durenberger bill is strictly employment related, but the Gephardt-Stockman proposal would allow people outside the work force to enter the system during open enrollment periods. Individual health care plans may be permitted to limit the number of high-risk individuals they enroll, however, so people with cystic fibrosis or other chronic conditions may have a far more limited choice of plans than the general population. The creation of a special actuarial category such as that mentioned previously, for periodically disabled or limited income workers, might be another way to help ensure the accessibility of reasonable health care coverage to all who need it.

C. MINIMUM BENEFITS/ADEQUATE COVERAGE

Major advances in attitudes about at least two aspects of medical care are evident in the legislation now under review: There is virtually unanimous agreement that families must be protected against financial disaster caused by illness; and the need for services to prevent disease and promote health is gaining widespread recognition.

For people with cystic fibrosis, these two factors are particularly important, since the family of a cystic fibrosis victim may face what amounts to catastrophic expense during every year of the patient's life, and a significant portion of that expense is likely to be for drugs, dietary supplements, and physical therapy that could appropriately be called preventive health care.

In all, the medical care requirements for the treatment of cystic fibrosis are staggering when compared to the needs of relatively healthy people. Basic health care for the typical cystic fibrosis patient consists of extensive drug treatments, dietary supplements, physical thearpy, clinic visits, and laboratory tests; in addition, hospitalization at least once a year for two to three weeks is not unusual for many cystic fibrosis patients. It is easy to see how the average annual cost of cystic fibrosis care can quickly mount to $6,000 to $12,000 per patient, as estimated in the report of a 1981 Cystic Fibrosis Foundation survey. The threat of financial disaster for the individual or family in such a case is clearly a matter that impels congressional attention.

All three of the major procompetition bills include some provision for a ceiling on the amount that any individual or family must spend on medical services in a year. The Hatch bill imposes a ceiling on out-of-pocket expenditures at 20 percent of earnings from employment. The other two plans set specific dollar limits on out-of-pocket expenses.

The problem here is that the definitions of out-of-pocket expenses appear to be based on eligible or covered services, and those are generally circumscribed by the medicare spell of illness concept; in other words, medical services may be covered to the extent that they are related to a definable episode of acute illness. While that seems a reasonale approach for the average—that is, usually healthy—family, the patient with cystic fibrosis can be expected to incur costs of thousands of dollars each year for drugs and therapy not related to a single acute episode or period of hospitalization.

For a number of cystic fibrosis adults, prophylactic medicines, home therapy, and regular checkups help them to stay out of the hospital and maintain their productivity. To meet the needs of this group, and of the families of children with cystic fibrosis, a plan for catastrophic coverage should take into account all out-of-pocket medical expenses, including drugs, related to the chronic condition; and the ceiling on out-of-pocket expense should include amounts paid for insurance premiums and ought to be based on a reasonbale percentage of income—no more than 10 to 15 percent, in light of other basic living costs—rather than a set dollar amount.

Similarly, the criteria for minimum benefits should be developed with some recognition that "adequate" health care is defined differently for different segments of the population. Proposals to date have specified the inclusion of "preventive" care, such as periodic screening for hypertension and cervical cancer; but for the person with cystic fibrosis, adequate preventive care also includes regular physician visits for monitoring the condition and, for many, the constant administration of antibiotics and other drugs to prevent the occurrence of life-threatening complications. There is the potential, under the current proposals, for the individual's having to bear this type of health care expense in addition to the designated catastrophic limits. A benefit package that supports these goals while also accomplishing the cost-sharing objectives of the competition proponents could be simply designed—which is itself a worthy goal—the plan would pay all of the first $150 or $200 for medical care received during the year, then none of the next $150, then 80 percent until the individual or family had spent 15 percent of its income on health care costs, at which point all further expenses would be covered.

All professional charges would be included on the same basis, whether hospital, lab, office visit, drugs, or equipment. Such a plan would encourage preventive care and early attention to illness, both of which are recognized to be cost-effective—although discouraged by most current plans—and there would no longer be a deterrent to outpatient care as opposed to hospitalization. Equally important, this plan would not discriminate on the basis of the diagnosis or type of care received, and everyone would face the same payment schedule.

Another serious problem affecting benefits for the chronically ill is the prevalence of insurance clauses that bar payment for "preexisting illnesses." The effect of such provisions is that people with cystic fibrosis must go without benefits for their medical care for months or even years, even when they have insurance. Every time a person changes jobs or insurance policies, a new waiting period begins. Such clauses could easily be modified to protect the insurers from fraud—their only legitimate concern—by barring payments only for conditions first detected or diagnosed during the previous 12 months. In this way, people with chronic diseases would not face unfair discrimination in insurance. Such a requirement should be added to any set of minimum insurance standards mandated by law.

Three. Will public assistance remain adequate for those who need it?

While the primary goal of competition bills is to limit society's spending on health care, we believe that goal is unacceptable if it is accomplished primarily by reducing public aid to those who need it. There is ample reason to fear that the competition bills would have this effect both directly and indirectly.

The direct reductions are easy to predict. Already the claim of greater administration efficiencies through block grants has led to reductions of 25 percent or more in a wide range of public health programs, and the President has asked for an additional 12 percent cut. These programs provided many of the subsidies discussed earlier in the context of care centers that have encouraged research, education, outreach, and other innovative health care programs. The loss of such subsidies threatens to impede the progress of medical research and health care on every front.

If a voucher system is adopted, it is certain that the average value of the vouchers will not increase with the rate of inflation in a given health care area. How easy it would be to "cap" medicare and medicaid when all that has to be done is to refuse to fund the vouchers beyond an arbitrarily designated level, regardless of whether adequate care is afforded at that level.

The indirect reductions of aid will be harder to see. Currently the health care system includes a number of cross-subsidies, many of them engineered by the Government to shift costs away from its programs. Medicare, for example, pays less for a unit of care than any other insurer; the others must pick up the difference. Many medicaid programs have similarly held down expenses through limits on what they would pay. If competition legislation forces the medicare and medicaid populations into the commercial insurance market, then the Government's buying power will be lost, and the preferential rates for that care will evaporate. Vouchers may be based on a pattern of spending and costs that would no longer exist, and the difference between the value of the voucher and the cost of adequate insurance would be higher than predicted.

Similarly, the cross-subsidy that overcharges primary care in order to prevent a further rise in the already high cost of tertiary care would be eliminated, and those who currently face financial difficulty would instead face financial disaster.

CONCLUSION

This Nation's health care system today is based on the philosophy that everyone should be allowed to participate and everyone should share costs where possible, whether through taxes, insurance or cross-subsidies, so that no one is bankrupted in an effort to get adequate medical care. The system has its flaws, but the goal is fair access for all.

Competition legislation proposes to rewrite that social compact. Under competition, risk-sharing would decline as people are encouraged to find insurance policies tailored to their specific needs. Cross-subsidies would be flushed into the open under relentless cost pressures. Tax support would decrease because of budget pressures. Those fortunate enough to be healthy, or to have the money to buy good care anyway, would prosper in a competitive health care system.

But what of the others? How will people with chronic illnesses finance their care when insurance becomes more expensive—if it is available at all—when Government support is cut back, and when the price of their care goes up as well? What will happen to specialized facilities such as the cystic fibrosis care centers when those centers become "too expensive" in the eyes of an insurer?

As costs become more important, insurers and other financers of health care can be expected to shed costs the same way they added them over the last two decades. Insurers will not make everyone's care a little more expensive; instead, specific populations such as the poor or the chronically ill will simply be dropped from the system, or specific benefits like prescription drugs will be eliminated from coverage. Those who belong to large employment groups—who often have the greatest ability to modify their usage of health care services—will have the clout to deflect any negative impact onto others, and they will hardly notice the change.

Thus far the debate over competition has been based on the theory that health care can be treated like any other commodity or service. In fact, health care is delivered to individuals—people whose needs are too widely variable and too case-specific for simple categorization. For people with cystic fibrosis and other chronic diseases, an experimental competition model could lead to untenable financial burdens and an irreversible impact on their state of health and general well-being.

Thank you.

Chairman JACOBS. Thank you, Mrs. Tulcin.

STATEMENT OF REESE ROBRAHN, EXECUTIVE DIRECTOR, AMERICAN COALITION OF CITIZENS WITH DISABILITIES, INC., ACCOMPANIED BY VINCENT G. MACALUSO, ASSISTANT DIRECTOR

Mr. ROBRAHN. Thank you, sir. I represent the American Coalition of Citizens With Disabilities. I am the executive director and I have with me this morning my assistant director, Vince Macaluso.

We appreciate this opportunity to express our concerns regarding the proposals you have before you, particularly H.R. 850 which has the stated purpose of reforming health care in this country by inducing more competition among insurers and providers.

Disabled people want and need reform in health care. As do others we support a universal and comprehensive system available to everyone at a price that everyone can afford. Disabled people, like older citizens, probably have a greater need for reform in health care available to them than any other group in this country. Insurance companies often try to avoid us as customers and try to price us out of the market. Some providers herd us into institutions, some treat us all like children whether or not we are, and some dispense to us a lower standard of care.

Most disabled people, like most older people, have less income than most others and a greater need for health care. Our health is seen by us perhaps more as a matter of life and death than it seems to others.

We really do not want to gamble on our health. To many of us health protection is as vital to us as is national defense. When politicans like Mr. Stockman call health care an economic good, we shudder.

Let us ask the question, as have so many others who have come before you, whether health care would and could in fact operate in the competitive mode given the structure proposed in H.R. 850?

We have serious doubts, mostly on the same grounds so well expressed by others like the AFL-CIO, the Economist Eli Ginzberg, segments of the health care industry itself, and other disability groups, including the persons representing the organizations on this panel.

I will review very briefly six reasons: No. 1, the seller, not the buyer, makes the important decisions about the nature and extent of care required and sets the prices for the same. Government intervention is needed directly with the sellers, the insurers, and the providers.

No. 2, the sellers can cut its costs without the buyer ever being aware. So in this kind of situation, the doctrine of caveat emptor would be outrageous.

No. 3, the buyer cannot be expected to have sufficient knowledge of the choices. Experts have argued endlessly over the comparability of insurance plans, health insurance plans. Medicare users have necessary coverages or inadequate coverages, that is their experience; and yet they, because of their age, have many years of experience in reading fine print.

What kind of marketplace behavior can we expect of our disadvantaged citizens who may be less literate or may be even illiterate and perhaps until just recently in institutions for mental retardation or for mental illness? They would play the role of victims under such a plan.

No. 4, every health provider would compete by attempting to provide a full array of services, just like the local full service bank. Therefore, more equipment and facilities would be purchased and put in place and would be more unused. Under these circumstances competition would thus tend to drive up costs and not drive them down.

No. 5, when medical providers make a virtue of maximizing profits, there would be a tendency to make orphans of certain kinds of rarely used services, just as there are now orphan drugs.

No. 6, the opportunities are endless for misleading and inaccurate advertising, of cost cutting at the expense of the patients, and discrimination against disabled and older people through experience—uprating preexisting conditions clauses and risk selection. And for bargain package policies that would have unacceptable omissions and substitute kinds of services.

On behalf of 36 million disabled people I want you to know that we do not believe that these matters should be left to the unilateral disposition of the industry itself, nor to the decisions, in its remoteness, of the Department of Health and Human Services.

All major segments of our citizenry must be represented in the procedures for setting up any kind of comprehensive health plan. So as you study the bills that are before you, we urge that you examine a real project which demonstrates how a system of this kind works for many millions of people and dozens of insurers and providers, including health maintenance organizations, Blue Cross/Blue Shield, service organizations, and indemnity companies.

I refer, of course, to the Federal employees health benefit program.

These organizations have competed for the business of the millions of Federal employees with all kinds of options and every year there is an open enrollment period.

Our observation is that this competition has not made the insurance providers behave a bit differently from the remainder of the industry. Certainly, their prices do not show that they have reduced costs.

In fact, from our brief observation their plan prices do not seem to have significant differences from other health insurers and sytems.

Our last conceptual concern is that there is a proposal for a voucher system in H.R. 850. We believe that it would constitute a health stamp system. All of the problems with fraud and abuse of such a system that we have experienced with food stamps would apply here but on a much grander scale.

In our written statement we have some technical objections and I will just designate them. We believe that it is not appropriate to tie this matter to the gross national product, we feel that there is not enough safeguard for high-risk persons in the proposals and we object to the exclusions, particularly emotionally ill and mentally ill persons, because we think that would be grossly unfair.

We believe that risks and benefits should be shared by all, there should be a common sharing. We feel that the result would be actually higher prices since emotionally ill and mentally ill people often seek inappropriate kinds of services.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF REESE ROBRAHN, EXECUTIVE DIRECTOR, AMERICAN COALITION OF CITIZENS WITH DISABILITIES, INC.

My name is Reese Robrahn. I am the Executive Director of the American Coalition of Citizens with Disabilities (ACCD). ACCD has both individual members and 135 organizational members. Its organizations are at national, state and local levels, and most of them are governed by boards with a majority of disabled persons. ACCD represents about eight million disabled citizens. Its purpose is to advance the legal, economic and social rights and interests of the 36 millon disabled people in this country.

We appreciate this opportunity to express to you our concerns regarding the proposals you have before you, particularly H.R. 850, which have the stated purpose of reforming health care in this country by inducing more competition among insurers and providers.

Disabled people want and need reform in their health care. As do many others, we support a universal and comprehensive system available to everyone at a price all can afford. Disabled persons, like our older citizens, probably have a greater need for reform in the health care available to them than any other group in this country. Insurance companies often try to avoid us as customers, or to price us out of the market. Some providers herd us into institutions, some treat us all like children whether or not we are, and some dispense to us a lower standard of care.

We really need the government's protection. Health care for us cannot be just another "economic good", as Mr. Stockman would have us view it. H.R. 850 and the other so-called pro-competition bills before you say to the American people: Go ahead and gamble. Reduce your health care protection because maybe you will be lucky. If you are lucky, you will not have to spend more money for health care. A few of the big gamblers can have a tax-free bonus which they may be able to spend on other things. If you are not lucky, well maybe you will be lucky next year.

Most disabled people, like most older people, have less income than most others and a greater need of health care. Our health is seen perhaps more as a matter of life and death than it seems to others. We really do not want to gamble. To many of us health protection is as vital to us as national defense. When politicians call it an "economic good" we shudder.

Let us assume now that our concerns are overwhelmed by other considerations. Let us ask the questions—as have so many others who have come before you—whether health care would and could in fact operate in the competitive mode, given the structure proposed in H.R. 850. We have serious doubts, mostly on the same grounds so well expressed by others, like the AFL-CIO, the economist Eli Ginsberg, segments of the health care industry itself, and other disability groups, including those on our panel, Paralyzed Veterans of America and the Cystic Fibrosis Foundation. Since the six reasons we mention below are familiar to you, we will go over them quickly.

First, the seller, not the buyer, makes the important cost decisions about the nature and extent of care, hospital procedures, laboratory tests, and so on. Government intervention is needed directly with the sellers (insurers and providers). Pressure on the powerless customer is pointless, as well as socially oppressive.

Second, the seller can cut its own costs to the detriment of both the buyer's health and his or her pocketbook without the buyer ever suspecting. The caveat emptor doctrine here would be outrageous.

Third, the buyer cannot be expected to have a sufficient grasp of the choices. Panels of experts have argued endlessly over comparability between health care insurance plans. People on the Medicare program are experiencing problems in procuring insurance to supplement Medicare. Many of them either have unnecessary coverage or inadequate coverage. (Medicare beneficiaries are a good cross section of mature citizens with more experience than the rest of us in reading of small print).

Who among us really gets familiar with what kind of benefits he has tucked away in his health insurance policy until he needs health care? What kind of marketplace behavior then could we expect of our disadvantaged citizens who are less literate, maybe illiterate, and perhaps even until recently in an institution for mental retardation or mental illness? They would play the role of victim.

Fourth, will not each medical provider seek to compete by offering a complete array of equipment and procedures, just as your local bank assures you it provides "full-line service?" To the extent that this is true, more CAT scanners will be underused and more hospitals will be performing difficult procedures, like open heart surgery, only occasionally. Not only will our costs rise, but the "success rate" in exotic procedures will drop. We are risking not only our money but our health and maybe our lives.

Fifth, when medical providers make a virtue of maximizing profit, will not there be a tendency for them to make "orphans" of services vital to a few but not yielding sufficient payoff to the provider, just as we already have "orphan drugs" now and for the same reasons? A lot of our constitutents need particular, complex treatments for which the demand volume in any single geograhical area is not large. Such treatments may be less available.

Sixth, in attempting to make this competitive model work we may ironically wind ourselves up in more expensive red tape than we have for the existing programs. No fair—nor, we hope, politically acceptable—competitive system can be developed without extensive participation by those whose well-being is at stake. The opportunities are endless for misleading and inaccurate advertising, for cost cutting at the expense of the patient, for discrimination against disabled and older people through experience rating, "pre-existing conditions" clauses, and risk selection, and for bargain-package policies with unacceptable omissions and substitute services. Speaking on behalf of disabled people, I want you to know that we do not think these matters should be left to unilateral industry disposition, not to the remote and often powerless labyrinth of the U.S. Department of Health and Human Services. All major segments of our citizens, such as disabled and older citizens, must be represented in the decision-making necessary to set up the rules for any such health program.

Finally, success in imposing one of these schemes to induce or to require people to accept less health insurance will probably have the effect of raising health costs in the end. Some people will gamble on their health, taking out cheaper policies. At the early signs of illness or disease they will then avoid the deductibles and copayments by postponing treatment until they become really sick. Then we will all pay more in terms of both money and the general health of our citizens. And the concept of health maintenance, so carefully nurtured over the past several decades and for such sound reasons, will be lost to us.

As you study these bills we urge you to examine a real project which demonstrates how a scheme of this kind works for many millions of people and dozens of insurers and providers, including health maintenance organizations, Blue Cross-Blue Shield service organizations, and indemnity companies. I refer of course to the Federal Employees' Health Benefit Program. These organizations have competed for the business of these millions with all kinds of options and every year they have an open enrollment period. Our observation is that this "competition" has not made the insurers and providers behave one bit differently from the rest of the industry. Certainly their prices do not show that they have reduced costs. In fact, from our brief inspection their plan prices do not seem to have significant differences from other health insurers and providers.

We have one last conceptual concern which we must address: proposals for a voucher system for those in the Medicare and Medicaid programs and other low-income people. We understand that the Administration is considering such a voucher system in lieu of Medicare and perhaps even for Medicaid. H.R. 850 of course offers vouchers to Medicare beneficiaries until half of them accept, and then requires the rest to use them and repeals the Medicare program; it also forces Medicaid recipients and other poor people to use vouchers whenever, after 1987, the state wishes to drop Medicaid. The problems we see in all these "pro-competition" schemes are equally applicable to those who hold vouchers. In addition, we expect problems with the voucher system itself, through bureaucratic error, theft, and fraud. We can judge the magnitude of these problems by looking at the experience of the food stamp program. (As others have said, these vouchers are "health stamps.") With food stamps, mistakes in determining how much in stamps a family is entitled to accounted for overissuance of 10.2% of food stamp dollars, according to the Department of Agriculture's most recent semi-annual report. Forgery and counterfeiting have become established rackets in some parts of the country, involving millions of dollars. In early September the Attorney General set up a new federal task force to investigate "serious abuses" in the food stamp program, including "massive fraud". Department of Agriculture food stamp investigators have now been authorized to carry sidearms. Since "health stamps" would have so much more value than food stamps, illegal traffic and more serious bureaucratic mistakes must be expected on a grander scale.

In addition to the conceptual problems discussed above, we have many technical problems with H.R. 850, S. 433 and S. 139. We list below some of our specific concerns with H.R. 850, in view of the sponsorship of H.R. 850 by the distinguished Congressman, Representative Gephardt, and a key Administration official, David Stockman, and because of the many poor people and people in the Medicare and Medicaid program whom we represent.

First, trying the Healthcare contribution to the GNP deflator seems clearly wrong. At best it makes the program even more of a gamble because health care costs and the Gross National Product are not very closely related. A recent forecast predicts that consumers would lose considerable ground over the next five years; the Congressional Budget Office report to your Subcommittee, which was placed into your record by Director Rivlin Wednesday morning, states at page 23 that the H.R. 850 voucher "would soon be worth much less than Medicare" because over the next five years growth in Medicare benefits per enrollee are expected to increase at six percent in excess of the GNP deflator. In the long run this relationship (of benefits to GNP) will vary also and become unreliable. We believe the only fair way of allowing for price increases is to survey the industry regularly or to provide that the voucher will equal the cost of the premium of the plan selected by the individual.

Second, "medically high-risk individuals" are not secure under H.R. 850. There are no standards to guide the Secretary of the Department of Health and Human Services in his definition of the term. There is no explicit ban on plans which bar treatment of pre-existing conditions. There is an ambiguity, if not a conflict, in the statutory procedures which would result in some "high-risk" people being left without any plan at all. No insurer has to accept a high-risk person if the plan already has its quota of such persons. Sec. 203(c)(2). But an insurer also is supposed to take those rejected by other insurers as a high risk. Sec. 203(d)(g). What if all insurers in the area have their quota? We fear that under H.R. 850 many disabled people would continue to be buffeted among insurance companies.

Third, a specific exclusion from Basic Health Care Services would eliminate a significant portion of the 36 million disabled people in this country. Plans may exclude items and services related to mental or emotional illnesses or conditions. Sec. 202(b)(2)(B)(iii). We agree with the statement of the National Mental Health Association, to be placed in the record of these hearings, that this exclusion (1) violates the basic premise of insurance that risk should be shared, and (2) is not cost effective. As the Association's data shows, when coverage for mental and emotional conditions is omitted, the cost for other medical and health services rises because many mentally ill individuals seek help in inappropriate ways. Adequate and appropriate mental health benefits reduce unnecessary use of other medical and health benefits.

These are just some of the problems we see with the bills before you. We will be glad to answer any questions.

Thank you for this opportunity to express our views on this matter of transcendent importance to the disability community.

Mr. RANGEL. Thank you very much, gentlemen. I don't know whether the chairman has advised you but an emergency legislative situation has arisen which will require the presence of half of the members of the subcommittee. So he has asked me to recess the hearings until 12:30 and apologize for any inconvenience that may have been caused to our witnesses.

We will expect to resume where we left off at 12:30.

[Whereupon, at 11:33 a.m., the subcommittee recessed, to reconvene at 12:30 p.m.]

AFTERNOON SESSION

Chairman JACOBS. We will resume. The committee will resume its sitting.

The next panel in order consists of the National Council of Health Centers, Mr. Jack A. MacDonald; the American Association of Homes for the Aging, David C. Crowley.

If you gentlemen will come forward and begin your testimony along the lines of our committee ground rules, we would be grateful.

STATEMENT OF JACK A. MacDONALD, EXECUTIVE VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CENTERS

Mr. MACDONALD. Thank you, Mr. Chairman.

The national council is the association which represents investor-owned multifacility nursing home firms. Our members own or manage over 1,100 nursing homes in 45 States and also provide many other health-related activities such as adult day care, home health services, retirement centers and alcohol rehabilitation programs.

It seems that competition has become the new catch word in Washington lately and many feel that it could be the panacea for what ails us; namely, increasing health care costs.

While we do not regard it as an instant cure, we believe that competition can play an important role as one element in a series of badly needed reforms of our health care delivery system.

We would like to direct our brief statement today to long-term care, an issue that has not yet entered the debate during the discussions of procompetition.

This is ironic for two important reasons:

For the elderly, long-term health care is their greatest potential expense; and

Aspects of a competitive market currently exist among nursing homes.

Everyone is well aware of the demographic trends in our country. People are living much longer, in fact, the population over 65 will double in the next 50 years.

Implicit in this trend will be an increased need for long-term health care services. That need will entail increasing our present capacity just to maintain our ability to provide services to the same percentage of the population that we do today.

For the long-term care industry, that represents a need for an 18-percent increase in capacity or 235,000 new beds by 1990.

At the same time, the need for noninstitutional care will also correspondingly increase.

Most policymakers, however, have steadfastly ignored this pressing information. In the deliberations of the past of such issues as national health insurance, catastrophic coverage or competition, there has been little or no consideration of the impending crisis in long-term care services.

Recognizing that we cannot continue to look to the State and Federal Government to finance our long-term health needs, the

National Council of Health Centers has begun to examine various concepts which could be integrated as part of a pluralistic approach to the financing and the delivery of these services.

We have enlisted the assistance of the public accounting firm, Deloitte, Haskins & Sells, to develop and discuss the advantages and disadvantages of these concepts given current social and fiscal realities.

These include: Block grant for long-term care programs; medicare and medicaid vouchers; supplementation for medicaid services; private insurance coverage of long-term care; and tax incentives for long-term care costs.

I would like to briefly describe the issues which will be included under these topics because of their relevance to the discussions today.

COMPETITION

As previously mentioned, the public debate on procompetition bills has focused on acute care. While this is understandable, we are dismayed that the potential for incorporating additional competitive elements into long-term care delivery has not to date been considered.

Real competition has long flourished among proprietary and nonprofit nursing homes and private-pay patients.

We suggest that the quality of care and scope of services have been greatly enhanced as a result and, further, these benefits have also accrued to medicare and medicaid patients as well.

Competition may well function better in the long-term care area than acute sector, given that the decision process may be more deliberative and quality factors easier to assess.

Additionally, there are a number of alternatives to select from among similar, yet distinctive, institutional and noninstitutional services.

As a result, an individual and his family has the opportunity to make marketplace choices regarding his long-term health care needs.

Thus, to those considering competitive proposals, we would strongly urge the inclusion of a catastrophic skilled nursing provision in the medicare voucher proposal. Consider the following:

Long-term care costs are the greatest expense for the elderly.

A 65-year-old person has a 1-in-20 chance of entering a nursing facility; an 80-year-old has a 1-in-5 chance.

While sold to the American people originally as a panacea for the elderly's health care costs, medicare has been sadly deficient in paying for those costs.

We urge that the committee consider this in its deliberations over H.R. 850 or any other competitive legislation.

I will simply submit the rest of my statement for the record.

Chairman Jacobs. Thank you.

[The prepared statement follows:]

STATEMENT OF JACK A. MACDONALD, EXECUTIVE VICE PRESIDENT, NATIONAL COUNCIL OF HEALTH CENTERS

Mr. Chairman, members of the committee, my name is Jack MacDonald and I am Executive Vice President of the National Council of Health Centers.

The National Council is the association which represents investor owned multi-facility nursing home firms. Our members own or manage over eleven hundred nursing homes in forty-five states and also provide many other health related activities such as adult day care, home health services, retirement centers and alcohol rehabilitation programs.

It seems that competition has become the new catch word in Washington lately and many feel that it could be the panacea for what ails us . . . namely increasing health care costs. While we do not regard it as an instant cure, we believe that competition can play an important role as one element in a series of badly needed reforms of our health care delivery system.

We would like to direct our brief statement today to long term care, an issue that has not yet entered the debate during the discussions of pro-competition. This is ironic for two important reasons: For the elderly, long term health care is their greatest potential expense and aspects of a competitive market currently exist among nursing homes.

Everyone is well aware of the demographic trends in our country: people are living much longer, in fact, the population over 65 will double in the next 50 years. Implicit in this trend will be an increased need for long term health care services. That need will entail increasing our present capacity just to maintain our ability to provide services to the same percentage of the population that we do today. For the long term care industry that represents a need for an 18 percent increase in capacity or 235,000 new beds by 1990. At the same time the need for non-institutional care will also correspondingly increase.

Most policy makers, however, have steadfastly ignored this pressing information. In the deliberations of the past of such issues as national health insurance, catastrophic coverage or competition has there been little or no consideration of the impending crisis in long term care services.

Recognizing that we cannot continue to look to the state and federal government to finance our long term health needs, the National Council of Health Centers has begun to examine various concepts which could be integrated as part of a pluralistic approach to the financing and the delivery of these services. We have enlisted the assistance of the public accounting firm Deloitte, Haskins & Sells to develop and discuss the advantages and disadvantages of these concepts given social and fiscal realities.[1]

These include: Block grant for long term care programs; medicare and medicaid vouchers; supplementation for medicaid services; private insurance coverage of long term care; and tax incentives for long term care costs.

I would like to briefly describe the issues which will be included under these topics because of their revelance to the discussions of this committee.

COMPETITION

As previously mentioned the public debate on pro-competition bills has focused on acute care. While this is understandable, we are dismayed that the potential for incorporating additional competitive elements into long term care delivery has not to date been considered.

Real competition has long flourished among proprietary and non profit nursing homes and private pay patients. We suggest that the quality of care and scope of services have been greatly enhanced as a result and further, these benefits have also accrued to Medicare and Medicaid patients as well.

Competition may well function better in the long term care area than acute sector given that the decision process may be more deliberative and quality factors easier to assess. Additionally, there are a number of alternatives to select from among similar, yet distinctive, institutional and non institutional services. As a result, an individual and his family has the opportunity to make marketplace choices regarding his long term health care needs.

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[1] The first two of the Deloittee, Haskins & Sells papers, prepared under the direction of James Dwight, former Administrator of the Social & Rehabilitation Services, are included for the record. [This report has been retained in the subcommittee's files and is not printed here.]

Thus to those considering competitive proposals, we would strongly urge the inclusion of a catastrophic skilled nursing provision in the Medicare voucher proposal. Consider the following: Long term care costs are the greatest expense for the elderly; [2] a 65 year old person has a one in twenty chance of entering a nursing home, an 80 year old has a one in five chance.

While sold to the American people originally as a panacea for the elderly's health care costs, Medicare has been sadly deficient in paying for those costs. For example, only 38 percent of a beneficiary's medical bills are covered; less than 4 percent of nursing home patients are Medicare patients. The severly restricted Medicare eligibility criteria for skilled nursing care along with the failure to recognize the growing demographics has been extremely short-sighted and costly in terms of increased hospital costs. We are presently spending one billion Medicare and Medicaid dollars per year on hospitalized patients awaiting nursing home placement. These patients may either not be able to find a bed, or cannot qualify because of restricted eligibility, yet their hospital bills continue to be paid by Medicare or Medicaid.

It seems inequitable that end stage renal disease immediately qualifies a disabled person for Medicare; yet the elderly with chronic or terminal illnesses with little hope of rehabilitation are often refused coverage under Medicare.

We have been watching with keen interest the health maintenence organization demonstration projects for Medicare eligibles. Most surely nursing home and home based services will not only have to be offered as a benefit as an alternative to more costly hospitalization, but it will also have to be provided. The longer that a patient may be kept from a hospital, the less expensive it will be.

Similarly by including skilled care in a Medicare voucher system a seriously ill patient would not be forced into a hospital when his coverage expired.

Competition may also be instilled in the nursing home industry by changing Medicaid reimbursement practices within the states. For example, nursing homes might determine prospectively what per diem costs will be and bid to provide those services while meeting certain specified conditions. Inefficient and high cost providers would be forced to compete for the scarce public dollars that are available for care.

SUPPLEMENTATION

Basic to the pluralistic approach to long term health care is a belief in the need to reinstitute supplementation. We feel strongly that patients and their families should participate to the extent feasible in the costs for their care. It worked before and it can work again. Participatory supplementation need not be inherently onerous and is a natural outcome once we admit that we have finite fiscal resources available from the government.

A few years ago supplementation was an integral part of several state Medicaid programs. For example, after the Federally mandated termination of supplementation the state of Tennessee experienced a one time 28 percent increase in its intermediate care facility budget. The other states which had supplementation incurred similar increases in their Medicaid budgets.

Participation in this responsibility for the care not only increases the family and patient's awareness and participation in expenditures, it can also allow the state Medicaid program to provide either more services or services to more people for the same or less of cost to the state. For example, states might pay 90 percent of the specified costs while the patient and family would pay the remaining 10 percent. If the patient is without any family, then the state would pay the cost of the basic care of either an institutional or non institutional provider.

While supplementation may not provide the full solution to financing long term care, it can help to defray a substantial amount of the costs. Equally important, if not more so by involving the family in the process and developing their cost consciousness, the decision about the level of care and the provider is more likely to be the most appropriate in terms of cost, medical intensity and quality.

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[2] A National Profile of Catastrophic Illness, Abt Associates, under contract to the National Center for Heatlh Services Research, July 15, 1977.

PRIVATE HEALTH INSURANCE

An essential ingredient to financing long term care is the participation of private health insurance carriers. This participation, however, has been noticeably absent. While private insurance pays for 33.8 percent of private hospital expenditures, it pays only 1.5 percent of private nursing home expenditures. "Medigap" policies, the private insurance industry's contribution to financing health care for the elderly, are mostly available to cover the co-payments and deductible provisions of Medicare. We would suggest that such policies be considered as a means for families to insure against the supplemental payments for their elderly Medicaid eligible relatives.

We noted earlier the need for the inclusion of long term care services in a Medicare voucher system thereby allowing the individual match up a private insurance plan with the Medicare coverage. Equally important is for private insurance plans to begin offering such services as a benefit to the working population or their immediate families.

Historically two factors have been given as the excuse for why this has not taken place before: "Most people are not inclined to plan that far in advance for their long term health needs"; and "It is difficult to acturarially determine what the cost of such a benfit would be."

Those issures are now being addressed in a study on the potential market for private long term health insurance by the Department of Health and Human Service's National Center for Health Services Research. We are eager to see the results of that study, which should be available next spring and which will shed some light on the acturarial cost estimates. Based on those results the question can then be addressed as to whether long term care insurance coverage can be developed into a marketable package.

When one considers that 20-25 percent of the elderly may enter a nursing home in their lifetime, but less than half, about 45 percent stay for more than 90 days, therefore the size of the at risk population is relatively small both as to precentage and number.

The existence of private long term health insurance will assist many elderly in avoiding becoming totally dependent on the Medicaid program. This will also enable them to avoid becoming wards of the state and preserve their government intervention, administrative costs, less federal and state expenditures and a system that is spurred by private market forces and incentives.

An adjunct to private health insurance coverage for long term care would be the purchase of such coverage for Medicaid beneficiaries by the states. This carries its own set of problems which can and would have to be defined and resolved. But, it should be noted that some states have already examined and successfuly implemented elements of this approach through various reinsurance concepts. We would suggest that a stateweide demonstration program be considered to test the feasibility and effectiveness of this approach.

OTHER PRIVATE INITIATIVES

Additional financing sources which we are examining include the following:

Tax credits for families participating in the cost of the services furnished to an elderly patient in a long term care nursing home or in their private home.

Independent Retirement Accounts (IRAs) dedicated to the payment for long term care services.

Reverse mortgages to permit the elderly to use a portion of the equity in their homes to pay for long term health care needs without having to sell their homes outright.

Tax credits recognizing the fees of condominiums dedicated to congregate living which include long term care plans.

Taxing programs with revenues dedicated to long term health care such as excise taxes on liquor and cigarettes.

The proposals we have advanced today are deserving of your serious consideration. They all have at least one thing in common: they recognize the virtue of preserving and vesting in individuals the financial ability to decide on the services they wish to purchase within certain general guidelines. The underlying philosophy to this approach is that the private market place can provide many of the answers to our long term care financing needs.

STATEMENT OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING, ACCOMPANIED BY LAWRENCE LANE, DIRECTOR OF PUBLIC POLICY

Mr. CROWLEY. Thank you, Mr. Chairman.

I am David Crowley, accompanied this afternoon by Lawrence Lane, director of public policy.

My statement is relatively brief. I would just like to highlight the major points we have made. We see major distinctions between an acute care delivery system and long-term care. We also see potential reductions in quality as a result of competitive considerations and finally we have some comments on H.R. 850 and the use of vouchers in general.

The American Association of Homes for the Aging represents about 2,000 not-for-profit providers of housing for the elderly.

A substantial percentage of our homes participate in the title 18 and 19 public-pay programs as privately sponsored models of providing care to the indigent elderly.

Naturally, we feel that many of the procompetition ideas being discussed before this subcommittee, if implemented, would have a major impact on our members. For that reason, we are pleased to be able to speak to this issue today.

In our view, much of what has been promoted by the Department of Health and Human Services as procompetitive is nothing of the sort.

Reducing the Federal role in the medicaid program is not necessarily competitive. Cost-cutting measures, by themselves, are similarly not necessarily competitive.

Perhaps more importantly, placing a "cap" on Federal contributions to the medicaid program in the name of stimulating competition is little more than a pretense. One has very little to do with the other.

In the context of the subcommittee's consideration of these ideas, we would hope that the truly market-oriented ideas are separated from those which are merely recitations of past proposals to cut governmental spending.

Competition should never become a code word for the dilution of the public sector's commitment to the elderly persons in this country.

On the question of the difference between long-term care and hospital care, I would like to caution the Congress against simply extending acute care-oriented budget and competition proposals to long-term care.

The situations are sufficiently different that a primarily acute health-based plan may seriously, if not irreparably, impair the ability of long-term care providers to offer quality social, therapeutic and recreational services.

I would like to make three major distinctions, if I can, Mr. Chairman. It is an obvious point that hospitals and nursing homes provide for differing needs.

The hospital is virtually entirely devoted to responding to the health requirements of its patient population. A long-term care facility must respond to the health and social needs of its resident population.

People live in nursing homes, where ideally a sense of community is developed. A resident looks in large part to the home for the provision of a wide array of activities available to persons living independently, including, but not limited to, recreation, religion, social interaction, physical and occupational therapies, and comfortable and warm living conditions.

These activities are of tremendous importance to the residents, and are as much a part of their health regimen as the basic medical care that is offered.

In this light, a competition system based solely on the cost of health care would be extremely inappropriate for long-term care facilities.

It is vital that any arrangement which encompasses long-term care be truly reflective of the social components of care cited earlier.

Thus, we must be careful not to develop a system that would discourage the provision of social care in nursing homes.

The second major important point about the relative differences between hospital and long-term care facilities is the fact that nursing homes, unlike hospitals, generally face a greater demand for beds than are available.

In this context, incentives to attract potential residents by offering lower costs simply do not work. It is presently atypical for a person desiring admission to a nursing home to be able to choose from a number of immediately available living situations.

The attractiveness of a particular facility, then, would have small reference to its comparative costs. We cite in greater detail in our testimony, Mr. Chairman, but I will just allude to it briefly here the difficulties of trying to provide care for a minimal amount of money. I compare this with what's happened to our SSI program, in which a basic amount of income maintenance is available to low-income people. Beyond that, SSI recipients are left on their own to secure shelter and other necessities of life. We have also had a burgeoning increase in boarding homes. Some of them have had difficulties meeting fire and other safety, nutrition and sanitation standards. We are concerned about this loss of standards that have been set over a number of years, if the competitive model is adopted for long-term care.

I would like to make the third distinction between long-term care and hospital care. This distinction concerns the present dilemma of private paying versus publicly assisted residents.

Because of the virtually universal inadequacy of medicaid reimbursement rates to meet the actual cost of care, our association has supported the right of long-term care providers to seek private-paying residents to complement their medicaid population.

This means that the provider can seek a patient mix enabling the facility to maintain its financial liability while also being able to serve the indigent.

We have generally opposed proposals which would require facilities to admit medicaid-eligible residents and private-paying residents on a first-come, first-served basis.

This control over the admissions process has the important added benefit of preserving the provider's commmitment to the medicaid program as being generally consistent with their service goals and financial abilities.

These major points, Mr. Chairman, drawing the distinction between long-term care and hospital care are really at the core of our concern about competitive health care.

We have some specifics in our testimony related to the use of vouchers. We see some questionable assumptions in that approach, but we generally support the notion that because of the importance of this issue, additional study and debate needs to be focused on this question.

We are grateful for the opportunity to present our ideas this afternoon.

[The prepared statement follows:]

STATEMENT OF DAVID C. CROWLEY, EXECUTIVE VICE PRESIDENT, AMERICAN ASSOCIATION OF HOMES FOR THE AGING

I am David C. Crowley, Executive Vice President of the American Association of Homes for the Aging.

The American Association of Homes for the Aging (AAHA) represents not-for-profit providers of facility-based services to older Americans. Among our nearly 2,000 members are facilities which participate in the Title XVIII (Medicare) program as skilled nursing facilities and in the Title XIX (Medicaid) program as skilled nursing facilities and intermediate care facilities. A number of our member homes are involved in housing, health-related shelter and community outreach services which include day care, home health and nutrition services.

A substantial percentage of our homes participate in public pay programs as well as privately sponsored modes of providing care to the indigent elderly. Naturally, we feel that many of the "pro-competition" ideas being discussed before this Subcommittee, if implemented, would have a major impact on our members. For that reason, we are pleased to be able to speak to this issue today.

The concept of "competition" in health care has an appeal that is certainly widespread. It is not surprising that an idea to increase the incentives for cost restraint would find philosophical acceptance in many quarters. AAHA, too, is basically supportive of this goal, and would view with great interest all efforts to achieve a market-based health care system.

In our view, however, much of what has been promoted by the Department of Health and Human Services as "pro-competitive" is nothing of the sort. Reducing the federal role in the Medicaid program is not necessarily competitive. Cost-cutting measures, by themselves, are similarly not necessarily competitive. Perhaps more importantly, placing a "cap" on federal contributions to the Medicaid program in the name of stimulating competition is little more than a pretense. One has very little to do with the other. In the context of the Subcommittee's consideration of these ideas, we would hope that the truly market-oriented ideas are separated from those which merely are recitations of past proposals to cut governmental spending.

At the same time, we urge the rejection of any "market" proposal which signals a governmental decision to do so much for the elderly, but nothing beyond that point, leaving them to their own devices as part of a Darwin-type scheme. Competition should never become a code word for the dilution of the public sector's commitment to the elderly persons in this country.

We note that most if not all of the proposals currently in circulation are concerned with hospital care. Little or no effort has been devoted to the creation of a competitive model for long term care. On the assumption that some attempt will be made to develop such a system, we offer our thoughts on particular issues which must, in our view, be confronted and resolved before a competitive model would be appropriate. Also, we feel that the long term care components should be factored into any market-based plan which reaches the operational stage. Failure to do so raises the possibility that the resulting system either is prejudiced versus long term care, or locks long term care into an ill-fitting mode of purely economic decision-making.

At the outset, we must caution the Congress against simply extending acute care-oriented budget and competition proposals to long term care. The situations are sufficiently different that a primarily acute health-based plan may seriously, if not irreparably, impair the ability of long term care providers to offer quality social, therapeutic, and recreational services.

It is an obvious point that hospitals and nursing homes provide for differing needs. The hospital is virtually entirely devoted to responding to the health requirements of its patient population. A long term care facility must respond to the health and social needs of its resident population. People live in nursing homes, where ideally a sense of community is developed. A resident looks in large part to the home for the provision of a wide array of activities available to persons living independently, including but not limited to recreation, religion, social interaction, physical and occupational therapies, and comfortable and warm living conditions. These activities are of tremendous importance to the residents, and are as much a part of their health regimen as the basic medical care that is offered.

In this light, a competition system based solely on the cost of health care would be extremely inappropriate for long term care facilities. It is vital that any arrangement which encompasses long term care be truly reflective of the social components of care cited earlier. Thus, we must be careful not to develop a system that would discourage the provision of social care in nursing homes.

It should be understood that this is not merely a description of the "ideal" nursing home. The services I have just described are essential to even begin to meet the needs of those vulnerable elderly who are incapable of living independently. To ignore this fact is to return to the discredited and inhumane concept of "warehousing," which we fervently hope this Congress will never do.

A second important, relevant difference between hospitals and long term care facilities is the fact that nursing homes, unlike hospitals, generally face a greater demand for beds than are available. In this context, incentives to attract potential residents by offering lower costs simply do not work. It is presently a typical for a person desiring admission to a nursing home to be able to choose from a number of immediately available living situations. The attractiveness of a particular facility, then, would have small reference to its comparative cost.

Factors of greater relevance include the reputation in the community for quality, and the capacity to offer the types of care and services required for the particular applicant. A market-oriented assistance program must be able to account for these basically noneconomic indicators. Given the full occupancy levels of most nursing homes, it is important that quality, as well as cost, be a major motivating influence in the design of any alternative assistance system. In other words, we fear that the primacy of cost reduction may be at the expense of quality. If quality is downgraded as a factor, then a likely result would be the "leveling" out of care among facilities at a minimum (or below) level. The differences between facilities would almost certainly deteriorate if they are forced to provide care based upon a limited definition of public assistance. The capacity to be different or innovative would thus be constricted to the detriment of the residents.

Perhaps an appropriate illustration of the severe problems emanating from a lack of emphasis on quality is in domiciliary care facilities, where a sizable portion of the residents receive assistance under the Supplemental Security Income (SSI) program. While there has been a growth in the number of residential living arrangements for SSI recipients, there has been neither the funding nor the commitment for the development and implementation of standards to ensure quality. The result, unfortunately, has been a noticeable lack of fire safety, sanitation and nutrition standards for many of these facilities. We would hope that the Congress will be more vigilant in the maintenance of standards for long term care facilities.

A third distinction concerns the present dilemma of private paying versus public assisted residents. Because of the virtually universal inadequacy of Medicaid reimbursement rates to meet the actual costs of care, AAHA has supported the right of long term care providers to "compete" for private paying residents to complement their Medicaid population. This means that the provider can seek a patient mix enabling the facility to maintain its financial viability while also being able to serve the indigent. With this aim, we have generally opposed proposals which would require facilities to admit Medicaid-eligible residents and private paying residents on a first-come, first-served basis. This "control" over the admissions process has the important added benefit of preserving the providers' commitment to the Medicaid program as being generally consistent with their service goals and financial abilities.

Similarly, a so-called voucher alternative should reflect this same sensitivity to the financial needs of homes which strive for quality multi-faceted care. We would urge that the case equivalent of any voucher system be sufficient to meet the actual costs of providing the medical and social care discussed earlier. Failure to do so should not be further compounded by a requirement that participating long term care facilities must accept these assisted residents on an equal basis with persons who can pay the full cost of care, without regard for the resulting deficits.

An indifference to this problem may have additional significance. As the availability of public monies is lessened, greater emphasis is placed upon community sources of funding in our nonprofit homes. We are not at all confident that such community supplementation can sufficiently compensate for the future compounding deficits that are certain to occur if homes are prevented from seeking private paying residents.

These and other issues raised in the public discussion of the procompetitive proposals are obviously complex, and are not subject to easy resolution. We applaud Congressman Gephardt's efforts in this area as stimulating a timely and necessary debate. H.R. 850 is most useful in bringing the issues and their varying implications into focus. While it is not our purpose here to give a detailed critique of H.R. 850, we would like to offer a few general observations for the Subcommittee.

H.R. 850 specifically provides for a voucher system for Medicare and Medicaid recipients, enabling them to "select the type of health care coverage that best suits their medical and economic needs." We must join the ranks of those who have voiced some concern over the ability of the at-risk populations, who are vulnerable because of age or multiple chronicities, to be informed consumers. While the theory behind the voucher has a certain appeal, it is doubtful that many of the indigent elderly and those persons with impaired mobility can make the sophisticated decisions that would be thrust upon them by this proposal. Efforts by the Department of Health and Human Services to educate the users of vouchers would have to be intensive and probably very expensive, without a clear probability of success.

While H.R. 850 would leave intact state quality assurance standards, it does not confront the anticipated inner tension between desired quality levels and reduction of funds targeted to achieve that quality. There has been a constant clash of competing aims in this area, and the bill, somewhat understandably, does not offer any solution to this conflict.

At the same time, we support the concept of multiple, qualified health plans for workers. In addition, we see merit in the requirement that catastrophic care must be offered in every such plan. These are welcome proposals, warranting immediate study.

As the various testimony has shown, the issue before the Subcommittee is not one of simply choosing between competition and regulation. It is inevitable that a final product will contain a blend of these concepts, and thus manifest free-market aspects to create incentives for cost reduction while perserving the government's stake in the process as a defender of the poor, infirm, elderly, and disadvantaged. Towards this goal, we commend to the Subcommittee's attention a systematic review by the Senate Finance Committee during the 96th Congress of proposals to utilize the Medicare and Medicaid programs to provide castrophic health care protection likewise, we think it would be useful to explore the use of the Internal Revenue Code to create incentives for the proliferation of privately-sponsored care. While we as an association do not endorse either of these options at this time, we do believe that they have the potential to free up significant resources, to be used in a more effective manner. AAHA shares the Subcommittee's serious concern over the rising cost of health care. We look forward to working with the Congress towards this aim, and toward enhancing access to and delivery of quality care for all of our citizens.

Thank you for this opportunity to express our views.

Chairman Jacobs. Thank you, Mr. Crowley. I assure the panel and the public that a great deal of study will be given to these various proposals before and unless any action is taken by this subcommittee to move any bill concerning the subject.

These are probing hearings, you might say. The administration, I note, has not made its proposal for competition in the health field yet. We are told that it may be delivered to this committee by the 21st day of December of this year.

So we have a lot of studying to do. We are grateful to the panel's contribution to that study.

The next panel includes the American Psychiatric Association, Dr. Allan Beigel, and the American Society for Adolescent Psychiatry, Dr. Paul S. Weisberg.

If those witnesses will come forward.

STATEMENT OF ALLAN BEIGEL, M.D., CHAIRMAN, JOINT COMMISSION ON GOVERNMENT RELATIONS, AMERICAN PSYCHIATRIC ASSOCIATION (PROFESSOR OF PSYCHIATRY, UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE)

Dr. Beigel. Thank you, Mr. Chairman.

Chairman Jacobs. I believe, gentlemen, you understand the rules of the proceedings, and we would be grateful if you would proceed.

Dr. Beigel. Thank you, Mr. Chairman.

If it pleases the subcommittee, I would submit the text of my prepared statement for inclusion in the hearing record.

I am Allan Beigel, professor of psychiatry at the University of Arizona College of Medicine and chairman of the Joint Commission on Government Relations of the American Psychiatric Association.

The APA is a medical specialty society representing over 26,000 psychiatrists nationwide.

Mr. Chairman, we endorse the decision to rely on competition as a national policy and believe that is how medical care is presently provided.

At the same time, we question the enactment of legislative proposals respecting competition as the best national policy for the health care delivery system.

Medical care is different from other kinds of goods and services, and it is these differences which severely qualify these proposals' use of competitive model as a means for analysis of what ails the health care industry, as well as the solutions which these proposals and their analyses suggest.

Consequently, we have serious reservations about the purported cost containment and productivity impact of the procompetitive health care initiatives.

We also have objections regarding the discriminatory and anticompetitive minimum benefit packages contemplated by these proposals that select out the mentally ill for no coverage.

The committee should understand that I am speaking of millions of Americans who are in need of treatment for severe mental illness, including 2 million persons diagnosed as schizophrenic, 2 million more who suffer from profound depressive disorders and more than a million with organic psychosis and other disabling psychiatric conditions.

I am speaking of as many as 25 percent of those elderly written off as senile, whose conditions are actually misdiagnosed mental illness by which, if properly diagnosed, could be treated and often reversed.

Worse, I am speaking of millions of children in this country who suffer from serious emotional disorders. I want to emphasize that we are speaking of a disease, mental illness, not the health, happiness, achievement of potential social welfare continuum.

We are speaking of treatments as aggressive as many life-saving physical health care techniques, not programs which seek to expand the consciousness or raise the awareness of the general public.

The availability of these treatments have been demonstrated to be cost effective in multiple studies by such organizations as the Washington Business Group on Health, the Equitable Life Assurance Association, Blue Cross of Western Pennsylvania, Kaiser Plan of California and the Group Health Association of Washington.

We would be happy to make these studies available to the subcommittee. I am very much aware that given the cost effectiveness of psychiatric treatment and evidence presented, that the next question will be, Why, then, are people not clamoring for better psychiatric benefits under current health plans?

In part, this is based upon misperceptions about the nature of mental illness and its treament, in part upon an individual's denial of becoming a victim of mental illness and, in part, upon stigma.

Time does not permit me to explain fully how this impacts on the willingness of payors to include appropriate psychiatric benefits for the mentally ill in various coverage programs.

But I can assure you that this is the case, as the present procompetition legislation proposals amply demonstrate. In this regard, it is important to point out to the committee that the American Medical Association formally examined the issue of discrimination in the conferring of health benefits by third-party payors in 1975.

At that time, the AMA's house of delegates urged, in reference to Government programs, that benefits be provided covering emotional and mental illness equivalent in scope and duration to those benefits provided for other medical or physical illnesses.

This position was restated in 1978 with reference to both governmental and private insurance programs. We have the major legislative proposals before us. While we find their objectives to be laudible, we believe they cannot be viewed as a panacea for the complex problems associated with constraining health care costs.

First, the competition proposals, if enacted, would not substitute for regulation. In fact, as already noted, it would be further cumbersome regulation.

For example, how would consumers know which doctors are qualified to participate or which hospitals are qualified to participate, other than through extensive regulatory interpretation?

Second, competition may not produce the type of effective price competition that would significantly lower health care costs.

For example, recent studies question seriously whether HMO's do, in fact, reduce costs.

Third, the competition approach will likely have many unintended perverse consequences.

Fourth and finally, the assumption of these proposals is that if consumers are given an incentive to save money on health insurance expenditures, they will have the expertise and desire to choose policies which provide maximum coverage for care needed in the future, as well as minimum coverage for care not needed at minimum total cost and at an appropriate level of quality.

However, past experience, as detailed in my written statement, indicates that consumers, because of stigma and other factors, do not usually turn to the inclusion of mental health care benefits when purchasing a total health care benefit package.

This oral presentation and my prepared statement is by no means exhaustive of the unresolved issues posed by the procompetitive health care legislation initiatives.

Nonetheless, I trust the committee will carefully examine these procompetitive legislative proposals and note that they pose as many problems as they address and, given the nature of the medical marketplace itself, they may not have the intended effects they seek, particularly if they continue to disenfranchise millions and millions of Americans with significant mental disorders.

Thank you very much.

Chairman JACOBS. Thank you, sir.

[The prepared statement follows:]

STATEMENT OF THE AMERICAN PSYCHIATRIC ASSOCIATION, PRESENTED BY ALLAN BEIGEL, M.D.

Mr. Chairman, I am Allan Beigel, M.D., Professor of Psychiatry at the University of Arizona College of Medicine and Chairman of the Joint Commission on Government Relations of the American Psychiatric Association. The APA is a medical specialty society representing over 26,000 psychiatrists nationwide. I am pleased to appear before you today to share the views and to address the particular concerns of the American Psychiatric Association on the important subject of pro-competitive health care legislative initiatives.

Mr. Chairman, as you know, the decision to rely on competition as a national policy, whenever possible, as the chief regulating force in the economy marked a significant step early in the United States' economic-political history.

We endorse that principle and believe that is how medical care is presently provided. At the same time, we question the enactment of legislative proposals respecting competition as the best national policy for the health care delivery system. Medical care is different from other kinds of goods and services, and it is these differences which severely qualify these proposals' use of the competitive model as a means for analysis of what ails the health care industry as well as the solutions which these proposals and their analyses suggest. Consequently, we have serious reservations about the purported cost-containment and productivity impact of the pro-competitive health care initiatives and objections regarding the discriminatory and anti-competitive minimum benefit packages contemplated by these proposals.

We are not anti-competition per se, but rather, we oppose an over-regulated approach in addressing the problems posed by the health care delivery system. The American Psychiatric Association supports competition and cost-effectiveness. They are not new concepts to physicians practicing in the specialty of psychiatry. We have taken the lead in instituting a Commission on Psychiatric Therapies and developing mechanisms such as peer review, both further assuring cost-efficient and effective treatment.

Let me discuss the prevalence of psychiatric disorder, the nature of mental illness and the cost effectiveness of treating these disorders from both a cost-containment and productivity point of view.

The Committee should understand that I am speaking of millions of Americans who are in need of treatment for severe mental illness, including two million persons diagnosed as schizophrenic, two million more who suffer from profound depressive disorders, and more than one million with organic psychoses and other disabling psychiatric conditions. I am speaking of as many as 25 percent of those elderly written off as senile whose conditions are actually mis-diagnosed mental illness, but which, if properly diagnosed, could be treated and often reversed. And worse, I am speaking of millions of children in this country who suffer from serious emotional disorders and many of whom do not receive treatment. The early detection and treatment of mental illness in children, and the prevention of psychiatric disabilities that otherwise may persist into adolescence and adult years, produce very large returns in long-term cost-effectiveness and enhanced productivity.

The National Institute of Mental Health's Biometry Division data indicate that millions of dollars are needlessly lost each year through reduced productivity of the millions within our workforce suffering from some form of mental illness.

This is emphasized in a study carried out by the Kennecott Corporation involving 150 men who received needed psychotherapeutic services. The study found that an estimated six-to-one benefit-to-cost ratio as a result of the program, and recorded a 52 percent attendance improvement and a 74.6 percent decrease in medical/surgical costs after the psychotherapeutic services.

In the longer term, productivity is also decreased as a consequence of those children and adolescents who have begun their own destructive cycle of school failure due to untreated (and often unrecognized) mental disorder. When we factor in the indirect costs of mental illness—parents remaining home with an emotionally disturbed child, suicide in a family, inappropriate health care interventions—the real costs increase severalfold.

I want to emphasize that we are speaking of a disease—mental illness—not the health/happiness/achievement of potential/social welfare continuum. We are speaking of treatments as aggressive as many life-saving physical health care techniques, not programs which seek to expand the consciousness or raise the awareness of the general public.

Each of the competition proposals before Congress would leave these millions of Americans without medical/psychiatric treatment or medical/psychiatric care and therefore prohibit them from remaining or becoming part of the working, contributing population that weaves the economic and social fabric of our nation.

It is precisely this—cost of lost productivity and absenteeism—which has brought the issue of available psychiatric treatment to the attention of the business community. Here in the nation's capital, the Washington Business Group on Health surveyed large companies to determine the extent to which they offered coverage of psychiatric disorders to their employees under their health plans and the cost/benefit of that coverage. Based on an analysis of data compiled by the companies, the benefits of psychiatric coverage to the employing organization were ranked as: Improved employee productivity; reduced absenteeism; improved employee morale; reduced hospital/surgical/medical utilization; and lower insurance premiums.

Across the nation, other studies have found similar positive cost/benefit returns to employers as well as workers:

The Equitable Life Assurance Association reported a $3.00 return in increased productivity for every dollar of treatment costs.

Further, the introduction of lithium for the treatment of manic depression, over the past decade, has resulted in heightened productivity of those in our work force suffering from this disorder—saving $1.28 billion in productivity alone during that ten-year span. Further, it has been estimated to have saved $2.88 billion in direct mental health costs.

These direct cost savings attributable to the availability of a full range of pyschiatric treatment have been well documented in study after study. It has been amply demonstrated that coverage of psychiatric disorders actually reduces other health care costs, providing a net cost savings.

Blue Cross of Western Pennsylvania assessed the medical/surgical utilization of a group of subscribers who used a psychotherapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from $16.47 to $7.06;

Kaiser Plan in California estimated that subsequent savings for each patient receiving psychiatric care were on the order of $250 per year. In a study which matched each of the 152 patients in the study group with a similar person who had a similar level of psychologic distress but who did not seek psychotherapy, the control group experienced virtually no change in health care utilization over the next five years. On the other hand, the study group (the group receiving psychiatric care) reduced its non-psychiatric outpatient visits by 62 percent and its inpatient days by 68 percent;

Group Health Association of Washington has found that patients treated by mental health providers reduced non-psychiatric physician usage by 30.7 percent in the year after referral for mental health care was made available compared to the previous year. Furthermore, laboratory and x-ray services declined by 29.08 percent.

In Texas, a longitudinal study (1973–1977) demonstrated that access to needed treatment for mental illness resulted in a reduction in mean length of stay of over-65 patients in inpatient facilities from 111 days to 53 days. This halving of hospitalization resulted in a cost reduction of more than $1.1 million.

Moreover, preliminary research findings from Group Health Association of Washington suggest that appropriate and available psychiatric intervention to a single member of a family in need of such care has a positive cost/benefit upon the medical utilization by the entire family. For example, a hypocondriacal mother, once provided with psychiatric care, not only seeks treatment for her own physical disorders on a reduced basis, but takes her child less frequently to the pediatrician for minor complaints. Her spouse is similarly subject to fewer medical interventions.

I am very much aware that, given the cost-effectiveness of psychiatric treatment evidence presented, that the next question will be: Why, then, are people not clamoring for better psychiatric benefits under current health insurance plans? In part, this is based upon misperceptions about the nature of mental illness and its treatment; in part on an individual's denial of becoming a victim of mental illness; and in part, it is based upon stigma.

Regrettably, the tragic fear and misunderstanding of mental illness still pervade the nation. The plight of those suffering from such disorders and the role played by psychiatrists in alleviating their pain are sadly all too often misrepresented to most Americans through the media, television and movies. The mentally ill are often being portrayed in a manner more laughable than compassionate, and all too often as being merely morally weak, not suffering from a respectable disease. This has the effect of heightening the stigma still further.

I don't believe this Subcommittee can expect many people who have been helped or who are being helped to recover from mental illness to step forward to plead for equitable health insurance coverage of their illness. Few are willing to stand before you, or before the insurance companies or their employers and say: "I had a serious psychiatric illness, and I have been helped," or "I am suffering seriously and my insurance coverage is not sufficient to permit me to seek treatment." Worse, since mental illness, as all other illnesses, more often than not strikes in a random fashion, many of those not suffering now from such an illness are not likely to be thinking about insuring against such an illness in the future, particularly when they deny ever falling victim to mental illness despite epidemiological evidence of the incidence of mental illness. As I note elsewhere in this testimony, people often do not or cannot think about what level of benefits they may require at some point in the future under a particular health plan, and unless they are insured against such an illness, the likelihood of greater costs—both in less appropriate but insurable care, and in lost productivity—is irrefutable.

As you know, a key feature of all pro-competition legislative proposals is the establishment of a minimum benefit package. Of course the question of what services should be part of the required minimum benefit package is primary. Respecting psychiatric benefits, the major pro-competitive health care initiatives either (1) specifically exclude treatment for nervous, mental and emotional disorders; or (2) pattern their benefits after Medicare which, through its reimbursement limitations, severely discriminates against psychiatric treatment.

It is only through the provision of minimum benefits that the danger of underinsurance on the part of the consumer is safeguarded against. Moreover, in an August 31, 1981 letter from the American Medical Association to the Office of Personnel Management, expressing its view that coverage for medical care should not be on a discriminatory basis, based upon the nature of the illness, it was stated:

"The American Medical Association formally examined the issue of discrimination in the conferring of health benefits by third party payors in 1975. At that time, the AMA's House of Delegates urged, in reference to government programs, that 'benefits be provided covering emotional and mental illness equivalent in scope and duration to those benefits provided for other medical or physical illness.' This position was restated in 1978 with reference to both governmental and private insurance programs."

It must be placed in the forefront of these discussions that the incidence of illness is random. Further, consumers are not at all times fully informed as to all the medical risks they are exposed to. To define a minimum benefit package which excludes coverage for a frequent random occurrence—mental illness—is to leave Americans unduly exposed to the very risks they seek to protect themselves against. After all, it is risk-adverse individuals who generate demand for health insurance against medical bills. For the Congress of the United States to define a minimum benefit package—which sets a standard of assurance for the nation that they are protected against the risks of illness—which omits coverage for a major illness risk is a serious mistake.

The present treatment of psychiatric benefits in the contemplated minimum benefits package is a serious problem. These deliberate limitations and/or exclusions violate the basic principles and spirit of the competition thrust—that is, they place undue restrictions on the types of services to be provided and consequently are anti-consumer choice as they deny consumers access to a full range of essential health care services and, further, impose tax penalties on those consumers seeking a full range of protection against the risks not covered by the minimum package. This constitutes unfair competition on our view, and is unduly discriminatory against a component of health care which makes significant contributions to both the cost-containment and productivity objectives of the pro-competitive health care initiatives.

As the American Medical Association further stated in the previously cited letter:

"An action by the Federal Government that specifically singles out those in need of psychiatric benefits in an attempt to restrict benefits would imply that treatment for a mental or emotional disorder is not as cost-effective or as important as treatment for a physical disorder. The AMA cannot accept this, as the purpose of treatment for either condition, i.e., returning the patient to a state of well being, is the same."

Having discussed the psychiatric benefit issue, we would now like to address other critical concerns respecting competition legislation.

The pro-competitive health care initiatives introduced to date comtemplate major restructurings of the health care delivery system and these proposals must be analyzed carefully not only as to their intended effects upon the health marketplace, but also as to their potential for negative unintended consequences. The simple fact is that the competitive model has never been fully tested. Nor are there sufficient empirical studies available to clarify the many questions and issues raised by these proposals. Therefore, we believe that consideration of these initiatives must proceed with due deliberation.

Clearly, it is the substantial escalation in the direct and indirect Federal payments of the costs of health care over the past twenty years that has prompted close attention to the issue of health care costs. It is largely out of this background, coupled with a perceived need to minimize the regulatory approach—which in fact may result in an even more cumbersome and onerous regulatory bureaucracy—that these proposals (including, we expect, the Administration bill) have come forward directed toward the establishment of an increased level of competition in the health care delivery system. These proposals involve fundamental changes in the way health insurance and services are selected and purchased as a means to stimulate cost consciousness among providers and consumers who eventually become patients.

While the overriding objectives of competition health care legislative initiatives are cost-containment and productivity in the provision of health care, there are several discrete and inherently contradictory objectives embodied in this legislative approach. The bills attempt to: Control federal expenditures through removal of open-ended commitments to Medicare and Medicaid and raise revenue via limitations on income tax deductions for health care expenditures; define an acceptable minimum level of services at a controlled level of expenditure; preserve the rights of individuals to allocate more resources to health care, while removing all federal incentives for them to do so; reduce the regulatory burden of federal and other governmental agencies that has contributed significantly to health care cost increases; and promote flexibility in health care delivery systems.

In short, the competitive health care legislation assumes that cost reductions can be achieved through market-place forces created by the competitive model resulting from: greater consumer acceptance of low cost insurance plans which make individuals bear the burden of health costs (through payment of co-insurance and deductibles at the time of care) and thereby reduce consumer demands for services; greater demand for (and insurer and provider willingness to provide) alternative delivery systems, such as HMOs and other forms of provider organization, which are able to deliver health benefits at lower costs and save the consumer premium dollars—or win him or her rebates; and increased competition among insurers of fee-for-service health care which forces them to lean harder on providers to be more cost-effective, ultimately forcing the least efficient providers to change or go out of business.

These laudable objectives do not mean competition legislation is, in fact, a panacea for the complex problems associated with constraining health care costs. First, the competition proposals, in enacted, would not substitute for regulation. In fact, as already noted, it would mean further cumbersome regulation. For example, how would consumers know which doctors are qualified to participate or which hospitals are qualified to participate—other than through extensive regulatory interpretation? Second, competition may not produce the type of effective price competition that would significantly lower health care costs. For example, recent studies question seriously whether HMOs do, in fact, reduce costs. And third, the competition approach will likely have many unintended perverse consequences and force compromises on many other public policy objectives concerning the health care and status of the American people. For example, what happens if the plan doesn't provide for neo-natal care?

Before proceeding with additional issues raised by the pro-competitive health care initiatives, we must lay the groundwork for what we believe are essential conditions supportive of a competitive environment in general. While theoretical in nature, these principles have a direct bearing on the pro-competitive proposals the Committee is considering and the nature of the medical marketplace to which they are addressed and with which we are concerned.

In a perfectly competitive situation, each buyer and each seller is such a small part of the market that, acting alone, he can have no influence over price or output. Moreover, buyers and sellers are well-informed and there are no artificial restrictions to the entry of new competitors. In such a world, sellers would be wholly responsive to prices set by an impersonal market. Each seller would produce those products which promise to bring him the greatest net profit. But since others could enter his trade if profits became abnormally high, the disciplining forces of the market would keep profits around competitive levels, that is, near the level where the enterpriser earned a sufficient return to cover his cost of capital, plus enough more to compensate him for the risks associated with running a business. Simultaneously, the consumer would allocate his purchases so as to maximize his own satisfaction. Out of these independent decisions of numerous buyers and sellers, the market thus generates signals that ultimately determine which products, and how much of each product, are to be produced and consumed.

The above, of course, would represent an overly simplified version of how the American health care industry is organized. Various government and private actions interfere with or complicate the decisions of consumers, providers and others. Moreover, the very nature of health care itself precludes that it be run on the basis of consumer sovereignty.

Nonetheless, from the above discussion, it can easily be gleaned that there are several principles essential to the operation of a competitive health care system: informed consumer choice; absence of regulatory barriers or restrictions; and absence of concentration of power in the hands of a few. While the pro-competitive health care legislative initiatives seek to create a more competitive environment, some basic questions must be asked as to whether they will create those features essential to support such an environment and to what extent other important policy objectives will be compromised.

In the arena of consumer choice the assumption of these proposals is that: if consumers are given an incentive to save money on health insurance expenditure, they will have the expertise and desire to choose policies which provide maximum coverage for care needed in the future as well as minimum coverage for care not needed at minimum total cost and at an appropriate level of quality.

Hence, individual consumers, if given a choice, will make knowledgeable and economically rational decisions that will set in motion a variety of salutary changes in insurer and provider behavior, We must empahisize here that there is little if any evidence that the incentive generally provided for in the pro-competition legislative proposals would have the desired effect. Further, and this must be underscored, health care is not a normal commodity, and individuals faced with illness and survival are not going to "shop" as they might for other commodities. The gap in information between consumer and provider is a fact respecting the health care decision process and one in which the physician has knowledge and expertise not immediately available to the consumer without the requisite minimum of eight years of education and training. Moreover, not only is the consumer not fully informed, but what is demanded is information itself. Consequently, fully informed consumer choice is at best limited due to the complexity of disease and the diagnostic process itself and the nature of the health care transaction as an information-seeking process. Hence, consumer sovereignty in this situation is severely impaired, and raises questions as to how fully informed the health care consumer can really be.

Current public policy regarding health insurance is based on the contrary assumption that individuals often lack the necessary information and ability to choose wisely among varied health insurance policies. Thus, rather than reduce the need for regulation of insurance packages and quality of medical care, the system proposed by these initiatives may require more direct regulation because the incentive would be to provide fewer services of lower quality. Having selected fewer services, what happens to the patient who needs intensive medical care and the latest scientific advances in treatment?

With respect to loosening current restrictions in the marketplace, these proposals overlook the problems addressed by the current body of regulations necessitated by both access and quality considerations which flow from the fact that the consumers' interests are at stake. Removal of such constraints as health planning, rate setting, and restrictions on the corporate practice of medicine may reduce governmental barriers to delivery of health care by qualified individuals and institutions. Deregulation is also an opportunity to remove many of the limitations on the scope of practice currently enforced by state government through professional licensure, thus permitting non-physicians to perform many of the functions now presently limited to physicians, and permitting technicians to perform many of the functions presently limited to professional nurses.

Proponents also perceive deregulation as an opportunity to eliminate state and federal regulations requiring institutional peer review. However, there is a real danger that deregulation of the health care system will be viewed as an opportunity to remove all governmental control of professional licensure so that some of the demand for health care can be satisfied by the unproved and possibly the unqualified resulting from self-serving certification. To suggest that the competition model can function without establishment of regulations which set the rules of competition is unsupportable.

Currently, medical care is generally delivered through a decentralized market with a large number of purchasers of medical services involving a large number of medical services. The legislative competition proposals generally anticipate greater concentration in purchasing power. Sponsors of insurance plans, particularly under the more comprehensive competition models, would be expected to exercise their purchasing power to control selection of providers and facilities through special arrangements with them and it is this anticipated competition among health service providers which will force greater market control over health care costs. The availability of care to plan subscribers would be governed by such arrangements, with controls established to limit costs and thus create a competitive advantage. These ends would be fostered through provider contracts, closed panel arrangements, negotiated fee schedules, and a greater reliance on large group practices, where costs theoretically could be lowered through strict internal controls. It can also be expected that market concentration would lead to large organizations contracting with providers for the provision of medical services to their own employees.

Such competition among providers clearly depends on the ability of competitive plans to bargain and contract with hospitals, physicians and other provider to lower charges and change the style of professional practice. Hence, competitive plans, including Health Maintenance Organizations and Individual Practice Associations, would be able to bargain successfully with providers to secure services at a lower cost, passing the savings on to their membership. Existing evidence, however, is not convincing that competitive plans will be successful in bargaining with providers to bring about the perceived needs for change in style of practice and control of costs. Illustrative of this fact is that HMOs, even with significant federal subsidies, have experienced limited success in establishing advantageous financial arrangements with providers and expanding enrollment.

This presentation is by no means exhaustive of the unresolved issues posed by the pro-competitive health care legislative initiatives. Nonetheless, I trust we have convinced the Committee that the pro-competitive legislative proposals pose as many problems as they address, and, given the nature of the medical marketplace itself, they may not have the intended effects they seek.

In closing, I not only urge careful analysis of the host of unresolved issues presented by so-called competition legislation, but also urge the Committee to remember the key to the good practice of medicine and the physicans' task of effectively treating patients—particularly for patients with a psychiatric disorder—is the individual patient, the heart of the doctor-patient encounter, not how much the treatment cost the Federal government, the real theme of this so-called competition legislation.

Chairman **Jacobs**. Mr. Weisberg.

STATEMENT OF PAUL S. WEISBERG, M.D., PAST PRESIDENT AND CHAIRPERSON, PUBLIC POLICY COMMITTEE, AMERICAN SOCIETY FOR ADOLESCENT PSYCHIATRY

Dr. **Weisberg**. I am Paul Weisberg, a past president of the American Society for Adolescent Psychiatry, and chairperson of the Society's Public Policy Committee.

The American Society for Adolescent Psychiatry has a membership of 1,700 psychiatrists concerned with the mental health needs for the adolescents of this country.

We thank you for giving us time to testify at these hearings. We hope to bring to your attention specific health needs of adolescents for minimum mandated levels of mental health care in lieu of anymore extensive coverage under health policies which their parents, the consumers, may choose. This is one case where the consumer does not choose. The adolescent consumer of the service is not the payor of the insurance premium.

When the adolescent dependent becomes ill, particularly in the area of mental health, lack of adequate health insurance coverage can be a precursor of a tragic outcome in their life.

Fortunately, most adolescent psychological illness can be treated on an outpatient basis, and a study done a few years ago shows that the median length of outpatient care for adolescents in a socioeconomically unweighted population is about 20 hours per year.

Similarly, hospitalization of adolescents, when it is necessary, because all the other environmental options have run out, is ordinarily short. Most often, a period of 3 to 6 weeks enables them to return to their schools, their families, and outpatient task. Some, to be sure, require longer hospital care.

When private insurance runs out two courses insue: If the family can qualify for medical assistance, the State in which the adolescent lives supports the treatment with Federal and State moneys. If not, the patient is discharged from care; he usually relapses and reenters the public care system either through a public mental hospital, or regresses into overt delinquency and the criminal justice system.

Adolescents age 12 through 20 constitute 15 percent of our population. They account for 40 percent of all arrests, 37 percent of all violent crime arrests, 62 percent of serious property arrests, and 57 percent of all serious crime arrests. And these numbers may be understated, since it is estimated that only about 3 to 15 percent of juvenile delinquent acts lead to a police contact, much less an arrest.

A profile of offenders has been constructed which shows that the typical offender is a male from a minority group with school problems, poor grades, interpersonal and conduct problems, high residential mobility, economic disadvantage, employment problems, families with high disorganization and instability, poor supervision, and poor parent-child relations. The factors that are most serious, most relevant in terms of delinquency are family factors, peer factors, and school factors.

It has been found that 71 percent of all serious crimes by youth are the product of law-violating groups. These are 5- to 10-member pickup crime groups without formal organization. More adolescents belong to these groups than to gangs.

Juveniles who begin delinquency involvement by engaging in serious crime tend to continue such criminality. An interesting study out of the University of Pennsylvania says only 5 percent of adolescents who do not commit serious crime by the time they are 18 do so later. It is those who regress enough to back away from society and commit a serious crime during adolescence who tend to enter the criminal world on a full-time basis later on.

Serious delinquency culminates a process of detachment from social norms. While that process may begin with deficient gratifications from socialization patterns in early childhood, it is alterable at many points during development. Minor or status delinquency in the context of a crisis during adolescence signals an opportunity for such alteration. Prompt intervention at such a time can decisively reroute the adolescent's life.

One available source of data quantifying wastage of human resources attributable to deficient supply of mental health care for youth comes from Gunderson's work at the Naval Health Research Center in San Diego. That data shows that in recent years approximately 2½ percent of Navy personnel age 18 through 20 are lost to the service annually due to personality disorders and neurotic conditions. Most of these disabling disorders are susceptible to relief and correction with timely intervention during adolescent crisis points.

As the mechanic on television says, "You can pay me now or pay me later" during his message that oil filters protect against engine breakdown at modest cost. Our message is in the same vein: prudent mental health protection at modest cost saves extensive social disruption and human wastage.

At present, 24 States have passed legislation mandating some form of mental health insurance. Many additional States require insurance companies to offer mental health benefits to their subscribers.

Recent understanding of how crises affect adolescents and their families indicate that most crises resolve within 6 to 8 weeks, either with relief of pathological symptoms or a hardening of antisocial behavior into a chronic pattern. Decisive and effective intervention at this time can be of extraordinary long-range value to the adolescent, for both the youth and the family are then susceptible to change. At such times it is the psychiatrist, with both his medical and psychological training and expertise, who can best evaluate the complex medical, neurological, psychological, and social aspects of the crisis of turmoil in the adolescent.

In addition to supporting the AMA guidelines that would provide consumers with multiple-choice insurance options, supply a nontaxable rebate to employees when the plan they choose costs less than the employer contribution, and limit the amount of tax deductible premium payments that the employer can claim, the American Society for Adolescent Psychiatry believes that the mental health of the Nation's best hope, its youth, will be served by a federally mandated minimum mental health coverage for minor dependents of consumers. This minimum package should include at least six outpatient visits for psychiatric evaluation with 100 percent insurance coverage per year based on usual and customary fee schedules prevailing in the community, with coinsurance phasing up to 100 percent for visits in excess of 20 yearly. It should also include 100-percent coverage of the first 21 days of full hospitalization, with coinsurance phasing up to 100 percent for days of hospitalization in excess of 45 per year. Day treatment, with an intermediate level of intensity between outpatient and inpatient care should be covered fully for 40 days per year by insurance coverage, with coinsurance phasing up to 100 percent for days of day treatment in excess of 90 per year. This proposed level of minimum coverage should be required of self-insured plans as well as those underwritten by insurance companies, with sanctions via the denial of tax deductions. The plan would eliminate economic disincentives to crisis intervention and would, at the least, allow adequate time for effective diagnostic evaluation.

To fund the above minimum mandated plan, we recommend the creation of a pool, made up of all earmarked premium moneys from the health insurance industry and from self-insured plans. The pooling of all earmarked funds obviates risks of adverse selection and reduces Federal exposure, for only if the pool were exhausted would Federal guarantees be activated.

We believe that health care costs can be controlled without compromising efficient and effective health care delivery. But without a minimum mandate, many parent consumers will not be able or willing to provide needed care for their adolescent children with the consequence of frequent pathological escalations into delinquency, crime, suicide, alcohol or drug abuse in their offspring. Such adolescents all too often become a charge on society—a wasted human resource. We cannot afford that waste. We consider that this minimum support system is not only apt, but requisite, on a public policy basis, for the protection and enhancement of our society.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF PAUL S. WEISBERG, M.D., FOR THE AMERICAN SOCIETY FOR ADOLESCENT PSYCHIATRY

I am Paul Weisberg, a Past President of the American Society for Adolescent Psychiatry, and chairperson of the Society's Public Policy Committee. The American Society for Adolescent Psychiatry has a membership of 1700 psychiatrists concerned with the mental health needs of the adolescents of this country. We thank you for granting us time to testify at these hearings of the Subcommittee on Health concerning competition in the financing and delivery of health care. We hope to bring to your attention specific health care needs of youth for minimal mandated levels of mental health insurance, independent of the nature and terms of any health policies their parents may possess. Parents, who as consumers are the buyers of the health care coverage, rarely choose from among health care policies available to them on the basis of future expected mental illness patterns in their children. When their adolescent dependents become ill, particularly in the area of mental health, the lack of adequate health insurance coverage can be a precursor of a tragic outcome in the adolescent's life.

A cardinal principal of medicine is that early diagnosis and treatment prevent chronicity. Because the adolescent undergoes rapid psychological and physiological changes telescoped over a very few years (ages 12–21) it is important that those who are impaired be treated effectively to help them achieve their age-appropriate developmental level. Timely psychotherapy not only prevents self-destructive and societally-destructive behavior but dramatically restores healthy development. Fortunately most adolescent psychological illness can be handled on an outpatient basis; the median length of outpatient psychiatric contact is very close to twenty hours per year in socio-economically unweighted settings. (Weisberg, unpublished data). This median comprises crisis intervention, short-term individual therapy, group therapy, and longer term services for those whose maladaptation is based on entrenched pathological patterns. Increasing awareness of the importance of families in the life of the adolescent has led to the development and widespread use of family therapy. When combined with individual therapy, there is demonstrated evidence of increased effectiveness of care. Hospitalization of an adolescent takes place only when the degree of impairment stemming from his/her mental illness is too severe and potentially destructive to be contained within his environment. If treated in timely fashion, most of the adolescents need only short-term stays of three to six weeks in the hospital before they are able to return to their families, their schools and outpatient care.

Some, to be sure, need substantially longer hospital care for optimal improvement. Treatment for all these adolescents requires not only terminating their recourse to destructive actions, but aiding them in their developmental growth. This requires the creation of a reshaping environment that does for them many things their parenting did not, in the areas of modeling on adequate adults, consistent patterns of approach, and opportunities to integrate their attitudes around values leading to solid self-esteem. Their attitudes toward their family systems are thus reorganized and their ability to be educated in reestablished.

When private insurance runs out, two courses ensure: it the family can qualify for medical assistance, the state in which the adolescent lives supports further treatment with federal and state monies. If not, the patient is discharged from care, usually relapses, and reenters the public care system either through a public mental hospital, or regresses into overt delinquency and the criminal justice system.

Adolescents age 12–20 constitute approximately 15 percent of the population. They account for 40 percent of all arrests, 37 percent of all violent crime arrests, 62 percent of serious property arrests and 57 percent of all serious crime arrests. These numbers may be understated since only between 3 and 15 percent of delinquent acts lead to police "contact" much less an arrest. (Office of Juvenile Justice and Delinquency Prevention, Charles A. Lauer, Acting Administrator, before the Senate Subcommittee on Juvenile Justice July 9, 1981). A profile of offenders has been constructed. The model offender is male, from a minority group, with school problems, poor grades, interpersonal and conduct problems, high residential mobility, economic disadvantage, employment problems, families with high disorganization and instability, poor supervision, poor parent-child relations, and high morale around membership in a law violating group or "gang". Strongest causal variables of serious delinquency are family factors, peer factors and school factors. (Weiss and Sederstrom, the Prevention of Serious Delinquency: What to do?, University of Washington, National Assessment Center on Delinquent Behavior and its Prevention, 1981).

71 percent of all serious crimes by youth are the product of law violating groups; that is, causal, 5–10 membership with no formal organization or turf. Juveniles who begin their delinquency involvement by engaging in serous crime tend to continue such criminality.

Juveniles who commit serious offenses are more likely to commit such offenses as adults than adults who did not engage in such criminality in juvenile years. Among those who had arrest records beyond 18 (at age 30) only 5 percent had arrests only beyond 18. (Wolfgang et al, University of Pennsylvania 1980). Tinklenberg and Ochberg found in California only 29 percent of violent youth assaulters acted without the influence of alcohol or illegal drugs.

Serious delinquency culminates a process of detachments from social norms. While that process may begin with deficient gratifications from socialization patterns in early childhood, it is alterable at many points during development. Minor or status delinquency in the context of a crisis during adolescence signals an opportunity for such alteration. Prompt intervention at such a time can decisively reroute the adolesent's life. (Marohn, et al, University of Illinois 1980).

One available source of data quantifying wastage of human resources attributable to deficient supply of mental health care for youth comes from Gundersin's work at the Naval Health Research center in San Diego. That data shows that in recent years approximately 2½ percent of Navy personnel age eighteen through twenty are lost to the service annually due to personality disorders and neurotic conditions. Most of these disabling disorders are susceptible to relief and correction with timely intervention during adolescent crisis points. (Gunderson, E. E K., private communication).

The mechanic on the television commercial says, "You can pay me now or pay me later" during his message that oil filters protect against engine breakdown at modest cost. Our message is in the same vein; prudent mental health protection at modest cost saves extensive social disruption and human wastage.

At present, twenty-four states have passed legislation mandating some form of mental health insurance. Many additional states require insurance companies to offer mental health benefits to their subscribers.

Recent understanding of how crises affect adolescents and their families indicate that most crises resolve within six to eight weeks, either with relief of pathological symptoms or a hardening of anti-social behavior into a chronic pattern. Decisive and effective intervention at this time can be of extraordinary long-range value to the adolescent, for both the youth and the family are then susceptible to change. At such time it is the psychiatrist, with both his medical and psychological training and expertise, who can best evaluate the complex medical, neurological, psychologial and social aspects of the crisis of turmoil in the adolescent.

In addition to supporting the AMA guidelines, that would provide consumers with multiple-choice insurance options, supply a non-taxable rebate to employees when the plan they choose costs less than the employer contribution, and limit the amount of tax deductible premium payments that the employer can claim, the American Society for Adolescent Psychiatry believes that the mental health of the nation's best hope, its youth, will be served by a federally mandated minimum mental health coverage for minor dependents of consumers. This minimum package should include at least six outpatient visits for psychiatric evaluation with 100 percent insurance coverage per year based on "usual and customary" fee schedules prevailing in the community, with coinsurance phasing up to 100 percent for visits in excess of twenty yearly. It should also include 100 percent coverage of the first twenty-one days of full hospitalization, with coinsurance phasing up to 100 percent for days of hospitalization in excess of 45 per year. Day treatment, with an intermediate level of intensity between outpatient and inpatient care should be covered fully for 40 days per year by insurance coverage, with coinsurance phasing up to 100 percent for days of day treatment in excess of 90 per year. This proposed level of minimum coverage should be required of self-insured plans as well as those underwritten by insurance companies. It would eliminate economic disincentives to crisis intervention and would, at the least, allow adequate time for effective diagnostic evaluation.

To fund the above minimum mandated plan, we recommend the creation of a pool, made up of all earmarked premium monies from the health insurance industry and from self-insured plans. The pooling of all earmarked funds obviates risks of adverse selection and reduces federal exposure for only if the pool were exhausted would federal guarantees be activated.

We believe that health care costs *can* be controlled without compromising efficient and effective health care delivery. But without a minimum mandate, many parent consumers will not be able or willing to provide needed care for their adolescent children with the consequence of frequent pathological escalations into delinquency, crime, suicide, alcohol or drug abuse in their offspring. Such adolescents all too often become a charge on society—a wasted human resource. We cannot afford that waste. We consider that this minimum support system is not only apt, but requisite, on a public policy basis, for the protection and enhancment of our society.

Chairman JACOBS. Thank you, Dr. Weisberg. In mandating inclusion of mental health care for qualified plans, would you include the psychologists or just the psychiatrists?

Dr. WEISBERG. It seems that the psychiatrist, because of his training and experience, has the best purchase on the very complicated social, neurological, medical, and psychological problems that occur to the adolescent, and that as the psychiatrist determines which flow pattern is best to establish for the adolescent, then the psychologist very often is called in. But the psychologist is not in a position, Mr. Chairman, to determine certain medical issues about that patient.

Chairman JACOBS. But the question is, when the psychologist is called in, should his or her services be covered by mandate along the lines you suggested?

Dr. WEISBERG. Within the limits of sessions, yes.

Dr. BEIGEL. If I may respond, I think the American Psychiatric Association, given the record of this legislation to date, is first of all concerned about the inclusion of mental health benefits in the first place. If that becomes an accepted portion of the legislation that goes forward we certainly are prepared to discuss the question which you have raised. I think our first and primary concern at this time is that mental health benefits be accepted as coequal part of any procompetition legislation developed by the committee.

Chairman JACOBS. Thank you very much, doctors, for your testimony.

The next witness is Dr. Robert Resnick, chairman, division of clinical psychology, Department of Psychiatry, Medical College of Virginia. Dr. Resnick is accompanied by Mr. Clarence J. Martin, executive director and general counsel for the organization.

Doctor, you know the rules of the New York State Athletic Commission.

STATEMENT OF ROBERT RESNICK, PH. D. (ASSOCIATE PROFESSOR OF PSYCHIATRY AND CHAIRMAN, DIVISION OF CLINICAL PSYCHOLOGY, MEDICAL COLLEGE OF VIRGINIA), ASSOCIATION FOR THE ADVANCEMENT OF PSYCHOLOGY, ACCOMPANIED BY CLARENCE J. MARTIN, EXECUTIVE DIRECTOR AND GENERAL COUNSEL

Dr. Resnick. Yes, sir.

Mr. Chairman, I am Robert Resnick, currently chairman of the Division of Clinical Psychology, Department of Psychiatry of the Medical College of Virginia. I am accompanied by Clarence J. Martin, executive director and general counsel of the Association for the Advancement of Psychology of which I am a member of the board of trustees.

I am here today representing the more than 32,000 licensed doctoral-level psychologists who help provide services to the more than 8 million Americans who utilize mental health services in this country each year.

There certainly is a cost crisis in health care, and part of the problem is the lack of competition in the health delivery system.

Per capita spending on personal health care has risen from $181 in 1965 to $941 in 1980—reflecting a 183-percent increase in prices and an 84-percent increase in the quantity of services.

This continuing increase in medical costs will have a substantial impact on the Federal budget, making movement toward a balanced budget that much more difficult. Federal spending for medicare and medicaid will total approximately $58.3 billion in 1981, and projections are that it will increase to $85 billion in 1984, almost 11 percent of total Federal spending in that year. The revenue loss from the tax exclusion for employer contributions to health insurance—which amounted to about $17 billion in income taxes and about $7 billion in payroll taxes in 1981—is projected roughly to be in the neighborhood of $34 billion in income taxes and $14 billion in payroll taxes by 1986.

Our current problems in health care were quite predictable. They were fostered by legislation that was well intended as health policy, but which had unfortunate side effects in the economy of the health care delivery system. Government intervention has exacerbated the distortion of natural market forces in health care that, in other industries, operate to determine both cost and quality and have encouraged the utilization of the most expensive settings and the most expensive technology.

For reform to succeed, it must abandon the current focus on "medical services"—that is, cures effected through surgery or medication. Reform must focus on the larger issues of health and consumer involvement in its maintenance. It must take advantage of an array of professionals who are licensed by their States to deliver a variety of health services; it must further consumer education in the appropriate use of services; preserve consumer choice in delivery setting and personnel; and reinstate financial incentives for consumers to choose wisely. According to the most basic economic principles, reform should remove the "support" structures that have become economic bottlenecks. It should replace Government intervention and artificial restraints in the supply side with marketlike competition; it should replace Government intervention and artificial inducements in the demand side with educated consumer control. Many of the private health systems that have already taken advantage of these principles have succeeded in reducing total costs considerably.

For these reasons we endorse several concepts included in the proposed legislation. These include: the control and equalization of employer contributions to employee health plans; requirements for coverage of catastrophic illness; extensive income tax reform including repeal of exemptions and deductibles that encourage first-dollar coverage, overinsurance and overutilization of health care services.

The health care consumer must be offered a wide range of health services, an opportunity to periodically amend that coverage, and an opportunity to be educated as to the relative costs and benefits of these options.

However, we believe that for true options to be available to employers and employees, competition would have to be restored to the health underwriters' market. Physicians currently control policymaking in the health insurance industry as they do in most regulatory interventions in health care. Physicians have used this control in the past, and can be expected to continue in the future, to inhibit competition with nonphysician health professionals, to keep physician's fees artificially high, and to stifle market influences on cost.

One example of the current health insurance market's failure to utilize competitive forces in the control of cost and quality is that the predominant carrier—Blue Cross/Blue Shield—is physician controlled. Blues plans nationally cover 48 percent of the insured population, and have participating provider agreements with 78 percent of practicing physicians. The Blues have traditionally advertised themselves as "the doctors' plan for doctors" and "the economic arm of the medical profession," and their history substantiates these claims.

Comparatively, over 700 private insurance companies in the United States which underwrite individual and group health insurance operate in competition with 70 Blue Cross and 70 Blue Shield plans, other hospital service and medical society plans, an increasing number of health maintenance organizations and similar group prepayment arrangements, a variety of uninsured plans sponsored by employers and labor unions, and a miscellany of other plans operating under the auspices of consumer cooperatives and fraternal societies.

In 1980, the largest insurance company accounted for 4.4 percent of the total business. The top four firms had 12.6 percent of the total premiums, and the top eight firms had 20.1 percent.

In many States Blue Cross/Blue Shield have received special sanctions under State law and regulation which give them a substantial competitive advantage in the insurance market and which provides the collective interest of their participating physician members with a mechanism to exclude nonphysician providers from the major market. Blue Shield of Virginia, for instance, insures 40 percent of the persons in its market area while hundreds of commercial plans compete for the remaining business, enjoys a geographic monopoly sanctioned by the State, and other distinct advantages over its potential commercial competitors. These include tax exemption and freedom from the regulation of investment policy, reserve requirements, and financial reporting.

House oversight hearings by the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce, U.S. House of Representatives found that the critical fee-setting boards in 68 of the 69 Blue Shield plans nationally are controlled by a majority of physicians. It is not surprising, therefore, that extensive investigation by the Federal Trade Commission's Bureau of Competition found evidence that physician control is used to keep physicians' fees artificially high, and to prevent and obstruct direct competition from nonphysician providers of health services (medical participation in control of Blue Shield and certain other open-panel medical prepayment plans: Staff Report to the Federal Trade Commission and proposed trade regulation rule, April 1979).

In some instances Blue Shield plans are wholly owned by State or county medical societies. Antitrust litigation brought by the Ohio attorney general against Ohio Medical Indemnity (the State Blue Shield affiliate) and the Ohio State Medical Association was settled by an agreement in 1979 that divested the plan of its physician ownership. However, absent active pursuit by large classes of well-informed consumers or State officials, physician control of Blues plans nationally have been sufficient to stifle and prevent efforts at cost control by commercial plans, which can be threatened with extinction through boycott or other organized anticompetitive actions by physicians (e.g., *U.S.* v. *Oregon State Medical Society*).

Blue Shield's self-claimed exemption from antitrust law under the McCarran-Ferguson Act has been recently denied by Federal appeals court (see Virginia Academy of Clinical Psychologists, et al. 624 F 2d 476 (4th Cir. 1980)(cert. denied)). But the act has greatly inhibited enforcement of antitrust law and prosecution of antitrust violations. Legislative history shows that congressional intent behind this law was to encourage State regulation of insurance companies, not just to exempt them from Federal scrutiny. However, according to a 1979 GAO report to Congress, "insurance regulation is not characterized by an arm's-length relationship between the regulators and the regulated." (Issues and needed improvements in State regulation of the insurance business, 1979). Insurance companies have not only been able to escape true regulation by their States, but the larger companies doing business in several different jurisdictions have sometimes avoided competition with numerous conflicting State laws.

Therefore, we believe that competition must be restored to the health insurance industry by correcting the anticompetitive controls maintained by physicians, and by removing the State and Federal shields that have preserved anticompetitive practices. In areas where competition does exist, the active oversight of independent agencies like the Federal Trade Commission is needed to assure its continuance. In areas where competition does not exist, the active enforcement of antitrust law by State and Federal officials, including the Department of Justice, is needed. Revisions of the McCarran-Ferguson Act such as provided by section 210 of H.R. 850 should be given serious consideration.

The greatest challenge to producing legislation which will provide competitive health care and cost reduction may be in constructing a health care package which is equitable to the consumer, raising the consumer's consciousness of health care costs and still allowing the insurance company a full opportunity to package innovative, efficient, marketable coverage through qualified plans.

Basic plans should be constructed to serve the needs for essential physical, mental, and preventive health care. Those who need specialized services or extensive services of some kind should be able to purchase add-on or optional coverage.

If qualified plans are to contain equitable coverage in their basic plans, the basic plans which fix the entry-level cost of insurance coverage must be constructed to provide safeguards against "skimming" or adverse selection. There may be limitations on basic benefits, but there should be no exclusions from basic benefits. These exclusions, such as the exclusion of mental health benefits from basic benefits in H.R. 850 build in adverse selection and are anticompetitive.

Under H.R. 850 all mental health users would pay for all mental health services (presumably offered as a separate or add-on benefit) but to receive that benefit all mental health users would be required to pay for part of the basic benefit package which they may or may not need. The mental health benefit user would also be induced to use those basic benefits because, after all, they are already paid for.

When, however, some mental health benefits are included in the basic insurance package, experience has shown the mental health benefit reduces costs.

This conclusion has been proven again and again in several decades of research studies on the benefits and cost-efficacy of mental health care within the context of overall health care costs. One recent review of this research literature "Impact of Alcohol, Drug Abuse and Mental Health Treatment on Medical Care Utilization," by Kenneth R. Jones and Thomas R. Vischi, published in "Medical Care," volume 17, number 12, December 1979, examined and critiqued research reports to assess the validity of their research methods and conclusions. Despite various questions about methodology, the authors concluded that the overwhelming evidence was that this mental health care clearly acts to reduce overall health care costs.

The importance of including mental health care within the package of basic benefits is clearly stated by four researchers who have been examining the effects of mental health treatment in reducing the overall costs of medical care. They state:

> An enormous (body of) literature suggests emotional factors may plan a role in disease processes and in treatment. Disease may be caused by or aggravated by emotional distress, which can influence the body's ability to recover from illness and surgery, patients' emotional responses to illness may influence both the doctor's decisions about medical treatment and the way the patient cares for himself, all with consequences for the course of disease, recovery, the maintenance of health and the use of medical services. The literature also suggest that psychotherapy or psychologically-informed procedures are a valuable addition to ordinary medical or surgical treatment. (Herbert Schlesinger, Ph.D.; "Effects of Outpatient Mental

Health Treatment on Medical Utilization of Persons with Chronic Diseases." Final Report of NIMH Grant, 1980.)

One of the best explanations for this overall reduction in costs can be found in the study by Nicholas A. Cummings and William A. Follette at the Kaiser-Permanente health maintenance organization in California. They concluded that patients with psychological problems overutilized physician visits, diagnostic tests, X-ray procedures, and hospitalization due to their efforts to find the causes of their physical symptoms. When it was discovered that physical complaints such as headache, back pain, stomach pain and ulcers, loss of sleep, lack of concentration, hypertension, and so forth, were actually caused or aggravated by psychological and emotional trauma such as stress, depression, and work/family tensions, this overutilization of medical care ceased. A 5-year followup study showed that this reduced pattern of medical utilization continued. Most importantly, short-term psychological care was effective in assuaging the vast majority of these emotional problems.

We believe that outpatient mental health services should be included in the basic benefit package. To enhance competition, however, it is even more important that mental health services not be specifically excluded from the basic benefits package, as they are in Representative Gephardt's bill, H.R. 850. It is contrary to basic tenets of a competitive approach to predetermine the boundaries of public market choice in this way. Such an exclusion may preclude companies that wish to offer innovative benefits packages from covering the full range of care procedures that have been shown to be effective in preventing serious disability and catastrophic costs.

Opposition to the inclusion of mental health benefits in health care packages has grown out of unfounded allegations that the costs of mental health care would seriously inflate total costs. These allegations, as shown by years and years of research, is simply not true. A reasonable, limited mental health benefit is in the best interest of effective health care and budgetary restraint.

The basic concept of insurance, spreading the risk among all members of a group, would disappear if the selection of mental health benefits users was allowed.

We agree with the intent of mandating basic benefits, but we feel that grounding the guidelines for this coverage in "medical" and hospital services fails to adequately define this concept. Specific references in current proposals to the services reimbursed by medicare especially belie what we have learned from the failures of this massive Federal experiment. Medicare has artificially inflated the cost of precisely the services it covers, and these include the most expensive kinds of care, often regardless of its appropriateness, delivered in the most expensive settings.

After the introduction of medicare, hospitalization rates among the elderly rose by 25 percent; average length of stay rose by 50 percent; and the amount of surgery on persons over age 65 rose by 40 percent. A recent study showed that medicare pays 36 percent more for fee-for-service care than for the same care to patients matched for age, sex, and location, but provided from prepaid group practices. Today medicare serves as a testimony to the problems of social service programs designed for the benefit of providers rather than consumers.

Essentially, medicare reimburses whatever services are delivered or ordered by a physician. Although direct payments to physicians constitute only 20 percent of total health care costs, because physicians serve as the entry point, evaluators, and decisionmakers for the disbursements of most medicare funds, they are directly responsible for more than 70 percent of total health care spending. According to Robert Derzon, former administrator of HCFA:

> These structural characteristics coupled with physician's central decision-maker role have resulted in a 214-percent increase in expenditures on physician services between 1965 and 1976 compared with a 145-percent increase in the gross national product. Over 65 percent of this increase was due to increases in prices for physician services, which . . . have been increasing faster than the consumer price index for the past three decades. (Statement before House Subcommittee on Oversight and Investigation, Committee on Interstate and Foreign Commerce, April 7, 1978.)

A more costly side-effect of physician control over medicare has been the system's unresponsiveness to consumer needs for the services which physicians cannot, are not trained, or are too busy to deliver.

Because of stigma, misunderstanding, and fear of abuse, and perhaps because of fear of competition from nonphysician mental health professionals, mental health services were severely limited in title XVIII. As the system has developed, the major portion of mental, emotional, and behavioral problems of medicare beneficiaries are being ignored, or inappropriately treated with physical interventions and in long-term institutions that provide little or no active treatment.

Persons over age 65 constitute 11 percent of our current population. Yet they account for 25 percent of all reported suicides and occupy a staggering 30 percent of all public mental hospital beds. As high as 30 to 40 percent of the elderly have problems with alcohol. According to former HEW Secretary Califano:

> Medical education has not fully come to grips with the issue of emotional and mental problems. By one recent estimate, 60 to 70 percent of mental and emotional illness, including alcohol-related problems, is treated in the medical system. This represents an important burden for thousands of physicians in the health care system: a burden for which too few are properly trained.

It has been discovered in recent research that between 10 and 20 percent of persons currently institutionalized as "senile" have been falsely diagnosed. The Conference on Treatable Diseases in the Elderly reported that one of the largest single causes of this false diagnosis is drug poisoning from overmedication, especially tranquilizers, and Valium in particular. Robert Butler, Director of the National Institute on Aging, has stated that more than 100 reversible syndromes, including depression, may also mimic senile dementia.

In direct contradiction of fears that mental health services would be abused, the elderly suffer more than any other subpopulation from fears of the stigma attached to mental problems. This reluctance to admit mental, emotional, and behavioral disorders, coupled with a discriminatory reimbursement system, has proven much more costly than the hypothetical abuse. Persons over age 65 use 2 percent of the services of psychiatrists in private practice, 4 percent of the services delivered in community mental health centers, and 37.5 percent of all prescription drugs dispensed in this country.

If your intent is to bring market forces to bear on decisions to purchase health services, we strongly urge that you do not tie reform to the medicare system. In fact, successful reform will require extensive revision of the current medicare structure. The tremendous demand for physician and hospital inpatient services stimulated by medicare has contributed significantly to their skyrocketing cost. At the same time, restraints on access to much ambulatory care and nonphysician providers have prevented medicare beneficiaries from taking advantage of innovative and cost-efficient advances in health.

We recommend that medicare beneficiaries again be mainstreamed into health care and maintenance. We support legislative proposals that would convert the more expensive, less predictable, and less controllable fee-for-service reimbursement system to premium contributions on behalf of medicare beneficiaries. If these contributions are fixed payments, as are necessary to create true consumer choice, medicare patients can be expected to opt for a variety of less costly alternatives.

There should be a uniform set of rules, such as those governing minimum benefits, premium-setting practices, and pricing guidelines for all health plans and all providers of health services.

Competition in health care should include more than simply competition among physicians, physician organizations, and insurance companies.

Boston University economist Thomas McGuire in his book "Financing Psychotherapy: Costs, Effects, and Public Policy," makes a strong and well-supported case for including nonmedical practitioners in any national health insurance program. Going beyond the clear points about competition and price, McGuire states:

> It is clear that a good deal would be lost by excluding or severely restricting the practice of psychologists under national health insurance. For the development of innovative forms of mental health delivery, it is essential that there be adequate supply of qualified mental health professionals capable of taking a leadership role in a variety of organizations, professionals without rigid preconceptions of the institutions within which mental health services are properly delivered. Psychiatrists alone would be too few and too inflexible. After the increase in demand, under a NHI plan, any psychiatrist would be able to make a very good living based on independent private practice; there would be little pressure to innovate. To give further encouragement to forms of mental health delivery that have recently shown great promise it is necessary to include psychologists as independent providers.

That competition in health should extend further than may be currently under consideration, grows out of psychologists' long-standing effort to provide competitive services in mental health care and the consumers' acceptance of these services as evidenced by the demand for mental health services. For instance, the Washington Business Group on Health reports that over 80 percent of their health plans include psychological benefits. Further, 10 States now require that a minimum package of mental health benefits be included in all health insurance plans. Ten more States require that consumers be offered the option of mental health benefits.

The American Psychological Association and our affiliated State psychological associations have worked to pass "freedom of choice" laws in State legislatures. These laws require that health insurance plans that include benefits for services that psychologists (by State law) may provide, must allow patients to have a freedom of choice of practitioners. These efforts, successful in 32 States thus far, representing more than 80 percent of the U.S. population, have sometimes been opposed by special interests but have been uniformly supported by both State and Federal courts as being procompetitive and in the consumers' interest.

For instance, in a recent case (*Virginia Academy of Clinical Psychologists, et al.*, v. *Blue Shield of Virginia, et al.*, 624 F. 2d 476 (4th Cir., 1980)) it was found that the Blue Shield organization, representing its physician members, acted in restraint of trade by refusing to comply with the Commonwealth's "freedom of choice" law. The appellate court found that clinical psychologists are professional competitors to psychiatrists—contrary to Blue Shield's assertions. To quote:

> It is not the function of a group of professionals to decide that competition is not beneficial in their line of work, (and) we are not inclined to condone anti-competitive conduct upon an incantation of "good medical practice." Moreover, we fail to see how the policy in question fulfills that goal . . . It defies logic to assume that the average family practitioner can supervise a licensed psychologist in psychotherapy, and there is no basis in the record for such an assumption.

We urge you to recognize the beneficial competitive force of nonphysician practitioners in your competition health plan. Recognition of psychologists, and other credentialed nonmedical health professionals, would clearly benefit efforts to decrease health care costs by increasing the pool of practitioners available for delivery of care. This is a fundamental economic principle. For instance, in a study by Richard Frank, assistant professor of economics and psychiatry at the University of Pittsburgh School of Medicine, it is concluded that in States with "freedom of choice" laws, fees for psychiatrists (psychologists' most direct competitor) are lower than in States without these laws—between 8.3 and 9.5 percent lower.

Simply, we suggest that the competition health plan recognize, and require reimbursement for, any health professional credentialed by a State to deliver health care services covered by an approved health plan.

Effective implementation of any procompetitive reform in health care will require the vigilant enforcement of antitrust laws on the business practice of professionals. The States' responsibility for protecting health, safety, and welfare of their citizens should be preserved. This responsibility includes the credentialing of health care practitioners, but should not properly extend to artificial restrictions on the place or conditions of practice, restrictions on truthful advertising, on dual practice with members of other professions, and so forth. To be effective, national competition-based health law will have to override these anticompetitive State restrictions.

For this reason, we support section 210(b) of Representative Gephardt's bill that would amend the McCarran-Ferguson Act (which exempts "the business of insurance" from Federal antitrust laws) by providing that the Sherman Act, the Clayton Act, and the Federal Trade Commission shall be applicable to policies of insurance or reinsurance offered to qualified plans and to persons provided such policies, regardless of whether such business or persons are regulated by State law.

Health maintenance organizations (HMO's) and independent practice associations (IPA's) have been hailed as true competitors in the health market. But we have serious reservations about the extent of real competition from these alternative systems. Already some Blue Cross/Blue Shield plans have converted their participating physicians wholesale to IPA participants. Such conversions constitute a difference without a distinction as far as patient services are concerned. But in 40 State jurisdictions HMO and IPA physicians are given additional protection from true competition with independent nonphysician professionals by restrictive State codes that prohibit interdisciplinary service corporations. Especially in areas where "closed" panels include the majority of practicing physicians, HMO's and IPA's may serve only as alternative mechanisms for physicians and local medical societies to maintain an anticompetitive advantage in the health market.

Fundamentally, all the HMO laws do is provide an antitrust exemption allowing some health care providers to fix prices in anticipation that they will reduce costs. If this exemption is allowed, as it is under present law to some providers (physicians) and not to other providers (psychologists) you are not promoting competition but sanctioning anticompetitive price fixing by part of the supply side of the market.

Since few advantages seem to have accrued as a result of Federal HMO regulations, since some of the most successful HMO's have never sought Federal approval, since Government is seeking a retreat from the health care business, and since the goal is to infuse competition to the health care market, we recommend the HMO Act include all health care providers on an equal basis, override restrictive and anticompetitive State laws and regulations, or be repealed altogether.

Thank you for your attention, and if you have any questions I will be pleased to answer them.

Thank you.

Chairman Jacobs. You are welcome.

Doctor, does your formal statement include some specificity about insurance plans where mental health is covered and costs have been adduced?

Dr. Resnick. Yes. It is in the prepared text that is before the committee.

Chairman Jacobs. That is my only question. We are happy to have that in the record and we thank you both for your participation.

Dr. Resnick. Thank you, Mr. Chairman.

Chairman Jacobs. The final witness for today is Dr. Di Paolo. Doctor, I am not certain whether the doctor is representing himself or the university. If you can identify yourself and make your presentation we would be grateful.

STATEMENT OF ROCCO J. DI PAOLO, D.D.S., FAIRLEIGH DICKINSON UNIVERSITY, HACKENSACK, N.J.

Dr. Di Paolo. Mr. Chairman, my name is Dr. Rocco J. Di Paolo, chairman of orthodontics at Fairleigh Dickinson University. I am here as an individual and would like to present my statement to you.

Chairman Jacobs. Please proceed, sir.

Dr. Di Paolo. Procompetition legislation can only achieve its purpose of reducing health care cost if we are able to avoid some of the abuses which may be brought about by unscrupulous operators "cashing in" on such legislation.

I have many areas of concern, two of which that should be considered and possibly be included in any procompetition legislation are the following:

1. Quality assurance must be an integral part of any procompetition legislation. Health care must be performed by individuals who demonstrate an acceptable level of competency. Poor diagnosis and shoddy treatment cannot be accepted no matter how low the cost of the delivery of health care. Patients that have to be re-treated not only may suffer a traumatic experience but also, depending on the procedure, may be at risk.

Patients must be assured quality care in any legislation which involves the delivery of health care.

2. In order to assure quality, national practice standards must be included in any procompetition legislation.

Presently, there are 50 States with their own medical and dental practice acts. To my knowledge, no two States' practice acts are exactly the same. Certain standards of treatment by a professional or an expanded duty auxiliary may be accepted in one State, and in another State the same treatment may be illegal.

In one State a professional may be suspended or lose his or her license for an illegal act, and in another State may only be fined or reprimanded for the same illegal act.

Procompetition legislation is needed to keep down health costs, but not at the expense of quality care. Patients must be assured that the providers of health care have a level of competency to administer quality care in any procompetition legislation.

National procompetition legislation requires national practice standards. A national standard of practice is needed in regulating the qualifications and competency of the professional dispensing health care. Those professionals who treat patients and are found to be incompetent or indifferent or who attempt to break the law, would be judged by the same national standard.

National practice standards would be an additional safeguard to the practice acts of the States and would be implemented and enforced at the State level.

These Federal standards of care would only deal with assuring the quality of care and would in no way be in conflict with State licensing laws.

An employee who shops around for comprehensive health care insurance could be assured that quality care will be given and the only cause for concern is the cost.

I recommend that guidelines dealing with national practice standards be developed by the appropriate professional organizations. Quality assurance must be included and implemented as an ongoing system in any procompetition legislation.

Thank you, Mr. Chairman.

Chairman Jacobs. Thank you, Doctor. Do you have an opinion as to whether there is a danger in the voucher system for medicare?

Dr. Di Paolo. I will answer your question, Mr. Chairman, this way: One of my concerns with the fee-for-service concept was that the health provider would probably add more cost during treatment. The opposite may be true with procompetition legislation. My concern is that if an individual provider is given a capitation, maybe not enough care will be given, since he or she will be paid the same amount.

Chairman Jacobs. I think that is the only question I have, Doctor. I express the gratitude of the committee for your contribution to the record.

Dr. Di Paolo. Thank you, Mr. Chairman.

Chairman Jacobs. This concludes the hearings at this time on the so-called competition in the health field. We await the administration's proposal, at which time I would contemplate that the committee would promptly convene further.

[Whereupon, at 1:22 p.m., the hearing was adjourned.]

[The following was submitted for the record:]

STATEMENT OF HON. WILLIAM M. BRODHEAD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I appreciate this opportunity to address the Subcommittee on the "procompetition" health care bills. I am pleased that the Subcommittee has begun to examine this legislation, especially in view of indications that the Administration will be proposing legislation along these lines next year.

I believe that health care costs to consumers, and to the federal government, need to be brought under control. I also believe that all Americans ought to have access to decent health care, regardless of their incomes. In my view, the legislation that has been proposed will achieve neither of these goals.

Each of the bills now under considertion calls for the taxation of some portion of employer-paid health benefits. In effect, this change will tend to discourage workers from obtaining as much health care as they believe necessary to protect their families. By offering rebates to workers who choose less comprehensive coverage, they encourage workers to gamble with their health and that of their families. Older workers, who cannot afford such gambles because the risks are too great, will have to pay more and more for coverage, out of after-tax, rather than pre-tax dollars. Workers will face a choice between accepting less health coverage, paying more for the same coverage, or probably both.

I consider the taxation of health benefits especially insidious because it would limit one of the few tax advantages which many average families use. The taxation of employer-paid benefits is an extremely regressive way of making up for revenues that will be lost as a result of the give-aways to the oil companies and others in the recent tax bill.

Another common feature of the "pro-competition" bills is their requirement that employers offer their employees a choice between various health plans. Again, this is merely a device for inducing workers to accept less coverage. Enforcement of this requirement would involve new regulatory activity by the Secretary of Health and Human Services, bringing additional costs which would ultimately be reflected in the price of health care. The requirement would also be disruptive to the collective bargaining process, where workers' representatives are already fully able to make choices as to the most advantageous plan.

In my view, these two features, the taxation of employer-paid benefits and the mandatory choice of plans with incentives for workers to get less insurance, make the "pro-competition" bills a major step backwards in the effort to see that all Americans have good health care. I also think that some of the underlying assumptions of these bills—for example, that health care costs have risen because of demands by patients for unneeded care rather than because of decisions made by doctors, and that health care costs will in fact respond to the increased difficulty in paying them that this legislation would impose—are not supported by the facts.

I hope that when the Subcommittee looks again at this legislation, it will reject bills that rest on such untested foundations and would have such harsh and regressive results.

American Association of Dental Schools,
Washington, D.C., October 7, 1981.

Hon. Andrew Jacobs, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means,
House of Representatives, Washington, D.C.

Dear Mr. Chairman: The American Association of Dental Schools is an organization representing all sixty dental schools in the United States, related dental auxiliary training programs, and hospital based dental general practice residency programs. We would like to submit a statment for the record relevant to the various "pro-competition" bills pending before the House Subcommittee on Health of the Committee on Ways and Means.

We are concerned about the adverse effect on dental benefits which we believe these bills would have if enacted in their present form. We understand the goal of these bills is to "stimulate competition in the financing and delivery of health care." However, we would point out that dental prepayment has not contributed significantly to the inflation within the U.S. economy. In fact, from 1967 when only 6.5 million people were covered by dental benefits, to 1981 when over 75 million people received dental benefit plans, dental care costs increased by only 155 percent as compared to 165 percent for all goods and services and 360 percent for hospital costs.

Dental insurance plans already utilize a variety of copayments, deductibles, and maximums to hold down costs. A wide range of plans compete in a market which has always been separate from other health coverage.

We are concerned that despite dentistry's good record in holding down costs, our services will be lumped with hospital-medical insurance in one large health insurance system. We believe this would destroy the dental plans which are now available to so many Americans.

Dental disease is unique in that it is not self healing An untreated cavity today will be a more serious problem in time, thus early treatment prevents more costly future repair. Despite this fact, the public often delays treatment until a dental crisis is at hand, because dental disease is seldom life threatening. Dental insurance solves this problem by encouraging beneficiaries to seek early and preventive treatment. The result is a *decline* in overall cost. In fact, dental care is so effective in preventing future problems that some plans impose a premium penalty for beneficiaries who do *not* visit the dentist within a certain time period.

We believe allowing individuals to elect dental insurance will encourage only those who know they need substantial expensive treatment to choose dental coverage. Moreover, these higher-risk, higher-claim people will opt out of the dental benefit plan when they perceive their treatment needs to be met. Dental insurance cannot withstand such adverse selection. The premiums which would be required under such a system would make dental care so costly that the plan could not be offered to anyone.

Dental benefit plans are currently effectively addressing the cost and selection concerns which the pro-competition bills raise, without the special adverse selection problems that would result from combining with the medical-hospital market. We believe strongly that it is in the public interest to allow this privately designed and separate market to continue as is, and urge that dental benefit plans be *exempt* from the restrictions, limitations and incentives contained in the legislation currently under consideration by your committee.

Mr. Chairman, we appreciate the opportunity to make these comments. If the American Association of Dental Schools can provide any assistance to you, the members of the subcommittee, or the staff, please do not hesitate to contact us.

Sincerely,

Harry W. Bruce, Jr., D.D.S.,
Executive Director.

Statement of the American Association of Nurse Anesthetists

This testimony is submitted for the record on behalf of the American Association of Nurse Anesthetists. Our Association is 50 years old this year and represents some 20,000 members. Approximately 17,000 members are in active practice. Nurse anesthetists administer approximately 50 percent of the anesthesia administered in the country. The American Association of Nurse Anesthetists is an organization whose purpose is to promote the science and art of anesthesiology; to develop and promote educational standards in the field of nurse anesthesia, as well as to facilitiate cooperation between nurse anesthetists, anesthesiologists, other members of the medical profession and the nursing profession and health agencies. We publish a scientific journal and we have a research capacity.

THE ISSUES: HEALTH CARE COMPETITION LEGISLATION AND THE PRACTICE OF ANESTHESIA

Like many other professional health associations we have many more questions about the so-called competition bills than we have answers or information. We are not at all certain at this point what the impact of proposed legislation which we have reviewed would be on the quality of patient care or on administrative mechanisms, of insurors, such as reimbursement methods. At the moment, we are not aware of what the Administration would propose and when such proposal is made we would hope to have some specific comments about it.

However, on the assumption that the competition legislation under consideration will be some what similar to bills already introduced, we do have a number of concerns and issues that we believe need to be addressed. One major concern relates to the group of recognized providers who could deliver health services under the qualified plans including any plans which were part of a Medicare-voucher program. A second concern relates to possible mechanisms which would provide for diversity with respect to the reimbursement of providers including individual professional providers which also provide competition based on the quality and cost of a specific service. A third concern relates to the educational process within hospitals and how it will be treated under a competitive health insurance system.

Issue 1: Quality of care

There are a number of methods used by states and private agencies to insure that the health care professionals delivering services are qualified. First, there are obviously the state licensing requirements and their definition of scope of practice for licensed health professions. Second, there is the process of examination and certification for health professionals in particular specialty areas such as the administration of anesthesia by nurses.

In the field of anesthesia, nurse anesthetists are subject to rigorous education, licensing and certification requirements. A nurse anesthetist must have a nursing degree and must undergo an extensive 2 year program of graduate-level education in the administration of anesthesia. That education must take place at a program which has been accredited by the Council on Accreditation of Educational Programs/Schools of Nurse Anesthesia which is recognized by the Department of Education as the accrediting body for education in this field. The educational program for a nurse anesthetist is at the graduate level and includes at its core courses in the chemistry and physics of anesthesia; advanced anatomy, physiology and patho-physiology; principles of anesthetic management; and pharmacology.

A requirement of at least 600 hours of clinical practicum in a setting in which students actually administer anesthesia exists and a minimum of 450 cases of anesthesia administration is required. A nurse anesthetist must then take a rigorous national examination in order to be certified as a registered nurse anesthetist.

We would support the use of existing mechanisms for assuring the proper education and quality of professional services in any new proposals dealing with competition in the health care financing system. There is nothing which we have seen in pending legislation which would lead us to conclude that this would not occur and we are not suggesting that the private insurance programs with which nurse anesthetists presently deal, such as Blue Cross and Blue Shield, are unconcerned about quality control mechanisms. We simply desire to voice the position that the system not emphasize the economics of the health insurance marketplace to the point where plans might be offered which are not sensitive to the kind of quality assurance mechanisms which we have listed above.

Issue 2: (a) Competition in the delivery of health care services

We wish to express our general support for a number of policy concepts expressed in competition legislation such as H.R. 850, as introduced by Mr. Gephardt at the beginning of this session. We agree that the purpose of fostering "the development of numerous, varied and innovative systems of providing health care which will compete against each other in terms of price, service, and quality" is a very important and necessary purpose of health financing legislation. H.R. 850, section 3(6). Likewise, we are very supportive of any legislation whose purpose is to "preserve the independence of health care deliverers and encourage their close identification with and their accountability to the individuals and the communities that they serve" [H.R. 850, Section 3(9)]. Furthermore, it is clear to us that the purpose expressed in H.R. 850, Section 3(5) of simplifying and rationalizing the payment mechanisms for health care services is a very important purpose and is critical to assuring appropriate competition in the delivery of services and the preservation of the independence of health care deliverers.

As most of you know, the payment mechanisms used in health insurance plans have a very direct and extraordinarily significant impact on how care is delivered and whether there is competition between health professionals who are engaged as providers of services. The structure of payment systems as well as the rates of payment are involved in this matter. The payment systems, like Medicare, which are structured in a very narrow way, recognizing only a very few providers for purposes of direct billing, have a very negative impact on diversity and on competition in the health care field. Such a system also has a very negative impact with regard to the independence of health care deliverers. If a health care deliverer has no right to directly bill, even though that person is authorized to deliver a service under state law and is delivering it in the appropriate setting, the individual is less independent. The professional is less independent because that person is dependent upon either another health care professional or an institution, such as a hospital, managing a person's practice in the sense of management of billing and receipt of payment for services. We believe that the health care system would function in a much more productive way if the insurance plans were like Blue Cross/Blue Shield with respect to payment mechanisms rather than Medicare. In this respect, we certainly are supportive of measures which would encourage the use of plans like Blue Cross/Blue Shield as opposed to the Medicare plan itself.

Our Association has a substantial amount of information about reimbursement systems under private health insurance plans, Medicaid, Medicare and CHAMPUS. We have done a number of surveys of our own members on these matters and we presently have a survey which we are doing with Blue Cross/Blue Shield plans at the local level. We think that our information is quite revealing.

As you probably know, a nurse anesthetist practices in a variety of settings. Our most current survey of our members indicates that approximately 65 percent are employed by hospitals as hospital staff nurse anesthetists. Another approximately 25 percent are employed in group practices in which physicians, principally anesthesiologists, are the partners in the group with the nurse anesthetists being employed by that group. Another approximately 10 percent of nurse anesthetists practice in their own group or individually. Billing for services to insurors will vary depending upon the setting of the practice. Obviously, a nurse anesthetist employed by a hospital will receive a salary from the hospital and the services of the anesthetist will be part of the hospital's billing for costs under Part A of Medicare. With respect to anesthetists who work in physician groups, billing could be done by the physicians for the nurse anesthetist's service and the anesthetist would receive a salary from the physician group. Where anesthetists practice in their own group, or individually, billing is either done directly if a plan allows direct reimbursement or is done by the hosptial which has contracted with the nurse anesthetist for his or her services. As you are aware, most anesthesia is delivered in a hospital setting although the development of ambulatory surgical centers has added another setting in which anesthesia can be delivered. As we mentioned before, nurse anesthetists deliver approximately 50 percent of the anesthesia in the country and it is of particular note that nurse anesthetists deliver between 65 and 70 percent of all anesthesia in hospitals of 100 beds or less. Thus, in rural areas or areas without major medical centers and hospitals, usually the underserved areas, the nurse anesthetist is the predominant purveyor of anesthesia services.

The information from our various surveys shows very clearly that payment mechanisms of insurance plans vary a great deal. Medicare will not directly reimburse a nurse anesthetist, nor any other health professional with the exception of a physician and a physical therapist. However, in our survey of all local Blue Cross/Blue Shield plans, of which now 31 have responded, 13 have indicated that they do directly reimburse nurse anesthetists.

Extrapolating from these partial results, approximately 45 percent of all Blue Cross/Blue Shield plans reimburse nurse anesthetists directly. The CHAMPUS program also pays nurse anesthetists directly and a number of state Medicaid programs do likewise. As you are aware, under Medicaid, states are permitted to directly reimburse any health professional. We do not have a survey of the state Medicaid agencies but only information from our own members. They indicate that a number of states do directly reimburse nurse anesthetists including California, Florida, Oklahoma, and Kentucky.

At the time of the enactment of Medicare, very few Blue Cross/Blue Shield plans, probably none, directly reimbursed nurse anesthetists. The trend is obviously toward direct reimbursement by private plans as the Blue Cross/Blue Shield information indicates. It is our opinion that this evidence supports modifying Medicare in order to have it provide for direct reimbursement where a certified registered nurse anesthetist is practicing in a nurse anesthetist group or as a solo practitioner and is practicing within the scope of the state license. The structure of Medicare was based on the structures of the private health insurance industry when it was enacted and, likewise, should be modified to reflect current trends in the industry of health insurance.

We do not think that a change in the billing mechanism of Medicare would in any way endanger the quality of care. We are suggesting that this change in the field of nurse anesthesia should occur only for certified registered nurse anesthetists, those with the education and qualifications we have explained above. A certified registered nurse anesthetist is always practicing in a setting with a physician since there is always a physician involved in operating procedures to which the administration of anesthesia is incidental. The recognition of quality of service delivery by a certified nurse anesthetist is found in the fact that at this time about half of the states require as a matter of state law that a registered nurse must hold a certificate as a nurse anesthetist in order to administer anesthesia. Likewise, the JCAH requires certification, or at least a documented equivalent, before nurse anesthetists practice in hospital settings.

In summary, we think that legislation which would encourage health insurors to adopt more diversified methods of reimbursement, including, specifically, direct reimbursement to certified registered nurse anesthetists, improve the effectiveness and the efficiency of the health care system. We believe that the Medicare system of reimbursement is not a sufficiently diversified or competitive one and we would urge that the Medicare model be changed.

(b) Medicare and vouchers

While we have read recently about proposals to convert Medicare into a "voucher" type of program, we are not aware of the details of such a proposal. We would generally be supportive of a proposal which allowed a Medicare beneficiary, if he or she so chose, to selct a private health insurance plan in lieu of using the Medicare insurance program, so long as the private plans included similar benefits to the current Medicare benefit structure. We do not want to see Medicare beneficiaries lose benefits or protection with respect to their current rights dealing with particular services. However, as we have mentioned in detail above, we believe that the Medicare reimbursement system is much too narrow and stifles diversity in the system. We think that the Medicare requirement that a nurse anesthetist practicing independently or with a group of nurse anesthetists, must bill through the hospital or through a physician is arbitrary and costly. A more rational and simple reimbursement structure would allow the private practicing nurse anesthetist to bill the insuror handling Medicare directly rather than have another intermediary in the system. This type of structure would be more in line with the trend of the private BC/BS plans to reimburse nurse anesthetists directly. We do not think that this kind of relatively minor change in the structure would in any way endanger the quality of care for patients receiving anesthesia. In our opinion, nothing would change with respect to the actual delivery of anesthesia and the setting in which anesthesia services are delivered. All present requirements with regard to practice privileges in hospitals and supervision would still be in place and obviously we are talking about only reimbursement for services rendered for an activity which is licensed by state law and delivered by a certified registered nurse anesthetist.

Issue 3: Competition with respect to health financing and its effect on education

We have a very deep and abiding concern about education for all health professionals. We are particulary concerned about graduate level education for nurse anesthetists, and for other health professionals such as physicians in residency programs, and about the problems which a competitive health insurance system might cause. Presently, most all of the 165 training programs for nurse anesthetists are conducted by hospitals. In this sense, the program is somewhat similar to residency training programs for physicians. Education in the field of nurse anesthesia is close to a desperate situation at present. The number of programs for training have dropped from approximately 235 to about 165 in the past few years. The evidence provided by a study done by HEW within the past 6 years indicates that there is a severe shortage of nurse anesthetists in the country. A 1976 study by the Bureau of Health Manpoower in HEW entitled "Supply, Need and Distribution of Anesthesiologists and Nurse Anesthetists in the United States, 1972-1980" projected a need of approximately 22,000 to 25,000 nurse anesthetists for 1980. At the time the study was done there were approximately 15,000 practicing nurse anesthetists and the supply is now approximately 17,000. The study therefore concluded that there was a significant shortage, approximaely 30 percent of the current of nurse anesthetists. Obviously a declining number of hospitals' educational programs is exacerbating this supply problem.

In the past 3 years we have made major efforts to solve this problem through the Federal legislative process and appropriations for the training of nurse anesthetists. The Nurse Training Acts of 1978 and 1980 included provisions for traineeships for students in the field of nurse anesthesia. Those programs, however, have not been funded largely due to the serious budget problems with which we realize Congress and the Executive Branch are dealing. The Carter Administration did propose funding at approximately 50 percent of the authorization level. While some nurse anestheesia students are receiving student loans under Department of Education programs, there is still a substantial need for support in the form of training stipends for the student and support for the educational institutions themselves. There are substantial costs in the form of space, equipment and salaries of teachers which hospitals have been absorbing in some large part, which have made it very difficult economically for the hospitals to maintain their programs; witness the decrease in programs.

We have a great concern that a competitive health financing system might result in pressure upon hospitals to reduce costs in a dramatic way and that the response to that pressure might well be to eliminate programs which are not directly service-related such as training programs.

Congressman Gephardt has anticipated such problems in Section 301 of HR 850 requiring that the Secretary of the Department of HHS make grants to or enter into contracts with entities other than educational institutions to compensate them for not more than 70 percent of the direct costs of providing graduate medical education and upon the Secretary finding that such compensation is necessary to provide training for needed health care professionals. Certainly our programs for training nurse anesthetists are accredited and we clearly believe that there is a great need for certified registered nurse anesthetists in the health care system. We are somewhat unclear about the details of how such a grant or contract system would operate. However, in principle we are very supportive of this provision in the bill introduced by Congressman Gephardt. We would strongly urge that such a provision be included in any health care competition legislation which the Congress, more particularly this subcommittee, were to report favorably.

We greatly appreciate the opportunity which you have afforded us to provide this testimony for the record. We hope that the comments we have offered are constructive. We are available to provide additional information and answer any question which any member of the Subcommittee or staff have on the matters which we have raised in this testimony.

STATEMENT OF THE AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION

The American Osteopathic Hospital Association represents the nation's 208 osteopathic hospitals. These institutions are located in 28 states, include more than 25,000 beds, admit nearly 880,000 patients per year, serve more than 3,750,000 outpatients each year, and in many cases are the sole hospital in a community.

The AOHA is pleased to present this statement to the Subcommittee on Health and to be one of the few national health care associations to endorse the concept of applying the principles of economic competition and consumer choice to the health care system. While we do not endorse any specific legislative proposal at this point, we do believe that the time has come to move away from increasing federal control of health care toward a system which relies on competing market forces for stability and control. In our view:

Governmental regulatory policies and programs have proven to be inefficient and inappropriate in containing health care costs; governmental legislative policies have increased the demand for health care services while regulatory policies have simultaneously attempted to shrink the supply of those services; governmental regulatory policies have effectively stifled innovative alternatives in the health care delivery system; and current regulatory policies have proven to be a major contributor to rising health care costs.

The alternative of further government interference in the health care system is, to us, not viable. Extensive government intervention in the system has failed to date. The time has come to let the professionals who are most capable—the hospital executives, the physicians, the other health care specialists, the insurors, and others—manage the system in a business-like manner. This is not to say that competition is a perfect mechanism—it is, to coin a phrase, more perfect than any other alternative before us.

Basic requirements of a system

We believe that a competitive model, to be successful, must embody certain basic principles. These include:

Free choice of provider as well as insurance plan by the consumer; major reorganization of the Medicare and Medicaid programs; substantial deregulation of the health care system; and the assurance that providers of health care services will have their full financial requirements met within the general principles of an open and free market based on generally accepted economic principles.

While we do not endorse a specific bill at this time, we believe that a number of provisions should be included. The remainder of our statement will discuss those specifics.

Specific recommendations

We recommend that, as a minimum, the following services be required to be provided by all plans.

Medical, surgical and obstetrical care; inpatient, outpatient and other institutional health services; home health or other institutional services for at least 100 days for any distinct spell of illness; well-child care, eye and ear examinations and immunizations customarily provided; prescription drugs incident to other basic health services; administrative fees for processing whole blood and blood products and derivatives; emergency transportation; medical services, appliances and equipment, including therapeutic devices and prosthetic appliances, and the medical services incident to their provision; and items and services related to acute mental or emotional illnesses or conditions.

We particularly recommend that acute, not chronic, mental or emotional illnesses be treatable under the basic benefits of any plan. It is our belief that such coverage is necessary in today's world.

UNIFORM BILLING AND CLAIMS

Any legislation to institute a competitive system should include a provision requiring all plans to use the same billing and claims forms. The possible proliferation of qualified plans could create a nightmare for hospital accounting departments. A uniform form should alleviate this problem. It would also be helpful if plans were required to provide hospitals with a listing of services for which it will reimburse. This will help hospitals keep track of what will likely be major differences between plans.

CATASTROPHIC COVERAGE

All plans should be required to provide catastrophic coverage, to be triggered when out-of-pocket expenditures by a plan enrollee reach $1,800 in a plan year. A higher trigger would create too many bad debts for hospitals from low-income families who can ill-afford such expenses. Basing the trigger on a percentage income expended would be too difficult to administer and would create needless red tape.

NONDISCRIMINATION

We recommend that a provision be included in any final legislative proposal which prohibits any plan from choosing a provider solely on the basis of medical degree or adherence to a recognized school of medical practice. Osteopathic hospitals and physicians have experienced discrimination in a number of situations for many years. Because of changing attitudes and legal protections which now exist, this problem has lessened. However, we strongly believe that a nondiscrimination provision is still needed.

TEACHING HOSPITALS

One of the most serious problems with all competition proposals now under consideration is the manner in which they deal with hospitals which have teaching programs. Postdoctoral education is expensive, and a teaching hospital will have serious problems competing with a non-teaching hospital which has no such program.

The primary question to be answered, in our view, is: "Who should pay for postdoctoral education?" Our answer is those who benefit most from well-trained physicians—the American public.

We recommend that criteria be established at the federal level which would be used annually to determine the direct cost of providing graduate medical education in every institution having an accredited program. These criteria would, of course, be developed with maximum input from the private sector. We realize this is a most difficult determination, but with the best minds from both the public and private sector working in the problem we are certain an adequate formula can be found.

Next, the total cost should be divided by the total number of individuals enrolled in qualified plans. Each plan would then be required to pay into a central fund an amount equal to the per capita figure times the number of individuals enrolled in its plan.

When all of the money is collected, it would be given to the teaching hospitals. This concept would pay 100 percent of teaching costs, would have the Amercian public paying for postdoctoral education, and would require the federal government to act only as middleman for the funds. It would also permit teaching hospitals to compete with others on an equal footing.

REPEALS/PREEMPTIONS

We agree with the premise that in a competitive arena, certificate of need laws, rate-setting programs and other restrictive provisions are not necessary. We would go so far as to say that state laws which regulate in these areas should be preempted. However, there are some laws at the state level which should not be preempted.

Of most importance in this regard are laws which prohibit the corporate practice of medicine. The preemption of such laws would inevitably lead to the proliferation of large competing units.

We believe there is a place for smaller units, that bigger is not necessarily better, and that any economies of scale achieved would be at the expense of many viable smaller units.

At the federal level, we concur with those who believe that health planning, PSROs, uniform reporting, the capital expenditure limitation in Section 1122, the Health Maintenance Organization legislation, and Hill-Burton can all be repealed in a competitive atmosphere. Each of these programs inhibits the ability of a hospital to exercise its management prerogatives and should be eliminated.

CONCLUSION

We believe a model containing such provisions could serve as a serious starting point for discussions about competition. It is our view that the time is now for those discussions to begin and we congratulate the Chairman for holding these hearings. This Association urges that this entire issue be given a high priority by the Congress and the Administration with the intention that a full program be enacted by the end of 1982.

We cannot afford to wait any longer to act. It will take many years for a competition model to be phased in. During those years, health costs will continue to rise. If we do not act now, pressure from the American public and other sectors of the economy will press for further government control. As we have said, further government involvement in health care will only exacerbate the problem.

We stand ready to cooperate in any way we can to speed the process along. We will answer any questions, appear before any forum and address any issue head on to assure that adequate debate occurs and that this concept is given a meaningful airing. The American people deserve a health care system that functions smoothly and efficiently; competition holds the key to creating such a system.

STATEMENT OF HERBERT ROTHFELD, D.P.M., PRESIDENT, AMERICAN PODIATRY ASSOCIATION

INTRODUCTION

On behalf of the American Podiatry Association, I am indeed pleased to present the profession's position on a subject of vital concern to all Americans. The critical issues we face in planning for, delivering and financing comprehensive health care services for all our citizens have produced a national debate. And our present health care systems require remedial attention before the "right to health care" can be assured for all persons.

The severity of these problems cannot be denied. Neither can we afford to delay any longer in finding and applying meaningful solutions. And since the Congress, the health community, and the American people do recognize these facts, the time for responsible action has clearly arrived.

It is not my purpose to herein restate the many symptoms of our present dilemma. This evidence has been abundantly documented for and presented to the Congress on previous occasions. Rather it is my intent to present, generally, our position with respect to an improved national health care scheme; to outline the principal objectives we believe any emerging pro competitive health plan should embrace; and, lastly, to express basic concerns we have about competition as debate on it unfolds.

APA POSITION ON NATIONAL HEALTH INSURANCE

The American Podiatry Association has made its position quite clear on the subject of an improved national health insurance scheme. At its 58th annual meeting in 1970, the Association's House of Delegates unanimously approved a resolution endorsing the need for, and desirability of, comprehensive health insurance for all Americans. Included therein was a charge to the profession to provide leadership and cooperation in the fulfillment of this essential national goal. And in cooperation with the Congress, the Administration and the American people, we will constructively pursue this mandate which, hopefully, can be achieved via some form of pro competition.

I do want to emphasize, however, that we do not view such a plan as a panacea for all the ills which now engulf the health community. With this in mind, we feel it is important that the Congress and the American people not adopt a system which does little more than subsidize and perpetuate the status quo.

We strongly believe that the debate and the subsequent enactment of any competitive plan should not occur in a vacuum. As important as it is to stem the tide on rising health and medical care costs, to which competitive directs its primary focus, other critical issues remain to be solved, too. In particular, I refer to well documented maldistribution and shortages among doctors of podiatric medicine and other disciplines. Furthermore, the health needs of the poor and the near poor, whose plights the pro competitive forces might neglect in their preoccupation with cost containment, must be meaningfully addressed by any enacted plan.

RECOMMENDED COMPONENTS OF A COMPETITIVE PLAN

With regard to a competitive health care plan, the American Podiatry Association has developed basic guidelines for its evaluation of specific legislative proposals. We feel that the following concepts, as a minimum, must characterize any plan to which the Association can give its support:

A competitive health insurance plan must be more than just a financing mechanism. It must recognize the need to improve the organization and delivery of health care services by promoting the comprehensiveness, continuity and accessibility of these services.

Any competitive plan must carry with it provisions to counter adverse cost trends.

Any plan enacted by the Congress must encourage, indeed require, a partnership effort. Neither the public nor the private sector can—individually or separately—fulfill the task. As a minimum, the government should provide financial incentives for a system which draws heavily on the private sector in managing and providing health care services.

Individuals must be assured the "freedom of choice" among both systems of health care and health care practitioners.

The enactment of a competitive health plan must be preceded or accompanied by further remedies for the deficiencies in existing public health insurance and assistance programs.

PRO COMPETITION—CONCERNS AND OBSERVATIONS

As previously noted, the American Podiatry Association supports efforts to make quality health care available to all citizens. Where competition can increase productivity, enhance quality, and stem the tide on spiraling health care costs, it should be encouraged.

A pro competition health plan is a subject of great interest throughout the health professions. It deserves to be studied carefully and thoroughly. There is little question but that current tax laws, some regulations and many incentives in health insurance plans tend more to inflate costs than to stimulate innovation and improve the delivery of services. In its deliberations, the subcommittee will hopefully find a pro competition formula which will effectively excise these undesirable barriers, for which APA pledges its full cooperation and support.

The idea of a competitive health care system has been very highly publicized. It raises the need for careful scrutiny by the Congress not only of the concepts and ideas involved, but also of the specific details. Competition as a panacea is a hypothesis, not a fact. The real world is not just a sector of the theoretical.

Pursuing the objective of improved health care delivery through a future competitive market system, special care must be taken to enhance, not weaken, the strengths of the present system. For example, "freedom of choice" is a basic principle which has distinguished the American system. Any seriously debated competitive plan must continue to support a patient's right to freedom of choice among both licensed health professionals and systems of care.

Additionally, any competitive plan should serve to untangle knots in existing government programs, such as Medicaid, which seriously limits a patient's freedom of choice, often times at significant costs to the taxpayer. Whereas podiatrists participate as "physicians" in Medicare, the same is not true with Medicaid, which narrowly defines that important statutory term (MD and DO). Thus, podiatrists participate in Title XIX as an optional service which state plans may or may not choose to cover. This is indeed unfortunate, since foot care remains a mandated Title XIX benefit, which the podiatrist, more so than his allopathic colleague, can more effectively administer. Also, the podiatrist's care is more frequently delivered in the office or on an outpatient hospital basis which lowers the cost to both the patient and the taxpayer.

States experiencing difficult problems controlling costs in their Medicaid programs may limit benefits to those mandated by the Federal law. It should be noted, however, that the removal of podiatrist's services from a state Medicaid plan does not eliminate the need for foot care, which remains a required Title XIX benefit. How that benefit will be subsequently treated, by whom and where, should be carefully evaluated by program administrators who hastily conclude that Medicaid costs will be reduced when podiatrist's services are no longer covered.

Some of the proposals for a pro competition health bill would offer strong incentives or even mandate the organization of providers of services into discreet sets of health care plans. The idea behind these proposals is to stimulate competition between these sets of providers who would be grouped in HMOs, IPAs, primary physician plans, preferred physician plans, alliances of solo practicing physicians, and so forth. The plans would theoretically compete on price to enroll patients. Ostensibly referred to a giving patients a "fair market choice," these plans in reality serve to limit rather than expand a patient's choice, since those very plans have inadequately considered the place in the market for ones other than medical doctors or osteopaths.

The pro competition model cannot yet be regarded as structurally sound, and this subcommittee can perform a valuable service by exposing defects before they widen. Although some of the strongest proponents of pro competition are of the opinion that the idea has been successfully tested and evaluated, the American Podiatry Association believes we are still a long way from having a structurally sound blueprint from which a successful plan can emerge.

CONCLUSION

I would conclude by noting that "cautious optimism" best characterizes the Association's position on a national pro competition health plan. Theoretically, it holds potential. But as an untried concept, we wonder if sufficient study has preceded any immediate national application of a competitive plan.

I appreciate the opportunity to present this testimony and look forward to constructively working with the subcommittee as it focuses attention on this vitally important subject.

THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS,
Park Ridge, Ill., October 14, 1981.

ANDY JACOBS, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR CHAIRMAN JACOBS: The American Society of Anesthesiologists is pleased to have this opportunity to submit the following comment for the record, in connection with the hearings of your Subcommittee on Health Care Competition Legislation, September 30 through October 2. The Society is a professional organization of approximately 13,000 physicians engaged in the specialty medical practice of anesthesiology throughout the United States.

In general, ASA supports the position of the American Medical Association on this legislation, as articulated in the testimony on October 2 of the Chairman of AMA's Council on Legislation, Fred C. Rainey, M.D. The Society wishes to stress its particular concern, however, over the provisions of H.R. 850 that would call for Federal preemption of state laws, in particular reference to staff appointment or admitting privileges in a hospital and to the type of medical services that could be delivered by specific categories of health professionals.

ASA is firmly opposed to the further "federalization" of the practice of medicine apparently contemplated by H.R. 850. To the knowledge of ASA, the Cngress has not been presented with any credible evidence that the current system of state regulation of the medical profession, and state definition of medical acts, has in any significant way "stifled" legitimate competition among health care practitioners. Unless Congress believes that it is in the national interest to remove all qualifications or licensure for the right to perform the healing arts, it is difficult to comprehend why a Federal system of licensure would better serve the American public than the system presently in place.

In the specific context of the provision of proper anesthesia care nation-wide, ASA points out that practice patterns vary significantly from state to state. In some states, virtually all anesthesia is administered by specialty-trained physicians, whereas in other states, anesthesia is administered both by non-physician anesthetists under the medical direction of a physician and by physician anesthesiologists. It is submitted that the current localized system of licensure is better equipped to respond to these differences in practice patterns than is any conceivable Federal regulatory program.

ASA thus urges the Subcommittee, as it considers the various "pro-competition" bills now before it, to reject the concept contained in H.R. 850 relating to Federal preemption of the current system of state definition and appropriate qualifications for performance of particular health care acts and procedures.

Very truly yours,

ELI M. BROWN, M.D., *President.*

BETHESDA HEALTH CARE ORGANIZATION,
St. Paul, Minn., October 6, 1981.

Hon. ANDREW JACOBS,
Chairman, Subcommittee on Health, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR CHAIRMAN JACOBS: I wish this statement to be included in the printed record of the Committee's hearings on competition.

I am a practicing, fee-for-service surgeon in St. Paul, Minnesota. I also am President of the Bethesda Health Care Organization, a pre-paid health plan which is participating in the Medicare pre-payment experiment.

As the Committee considers proposals to restructure the health care delivery system, I think it is important for it to know that I and a large number of other physicians believe that fundamental restructuring of our health care delivery and financing system is necessary in the public interest.

Reasonable cost/reasonable charge reimbursement must be replaced by a financing system which makes hospitals and doctors economically sensitive. Patients themselves should have incentives to compare various types of health plans and to make decisions which are based upon economic, as well as quality, considerations. Doctors and hospitals should be forced to compete not only in terms of quality, as they do now, but on price, and they should bear the consequences of their economic calculations. This price must be predetermined so that providers do not have automatic economic incentives to provide more care. New arrangements must be entered into between hospitals and doctors to bring them together in integrated delivery and economic systems. Physicians cannot continue to expect to make health care decisions which affect cost without being involved in the system which bears the consequences of those costs.

I believe our Health Care Organization is an example of what can be done. It can compete with other physicians by providing a better service to the patient at a reduced cost to him. We have carefully selected the physicians who will participate to ensure that we are working through physicians who not only provide high quality care but who can be counted upon not to over-treat, over-prescribe, and over-admit. Our approach will increase care and reduce costs. Both the physicians and the hospital with which the health care organization has contracted are at financial risk for over-utilization and both benefit from increased efficiencies.

Consumer choice and competition can work. Patients are able to make quality as well as price choices. It is far better to let patients, doctors, and hospitals determine how much care chould be delivered and by whom than to permit Government to make these decisions by regulation. Regulation does not reduce costs and may actually increase them. It turns over major health care decisions to people who do not have the necessary expertise and who are not responsible for their decisions. Economic competition can and should replace the complex and stiffling bureaucratic and planning controls under which we now suffer.

I believe physicians and hospitals will respond to the challenge and organize alternative delivery systems if the Government indicates that that is the way it wishes the system to be structured and gives beneficiaries the money to make a choice between that type of organization and more conventional forms of delivery.

Throughout the length and breadth of this United States the vast resources of the community hospital with its practicing physicians (the hospital medical staff), can be organized into an economically competitive unit and become responsive to legislative imperitives.

It is important, however, that the new structure not be controlled by government officials who have a stake in the present system. If there is going to be competition and deregulation, it must be for real.

All qualified provider groups must have access to the marketplace. In the current Medicare pre-payment trials in the Twin Cities of Minneapolis-St. Paul, our organization has only been provided access to the marketplace through the Blue Cross/Blue Shield intermediary. This has required us to live with the economic decisions of Blue Cross/Blue Shield, and prevented us from negotiating our own contracts either directly with Medicare patients or through alternative intermediaries. Therefore, we must accept that Blue Cross/Blue shield will retain from health care resources twenty percent of the health care dollar from the Medicare pre-payment trial for out-of-area coverage, secondary insurance, and management. This is as much money as is allocated for all physician services at all levels of the health care system. This inflated overhead is the highest of which I am aware among the many participating organizations in the Medicare pre-payment trial. Administrative costs of other organizations in such programs range from 6.2 percent (MedCenter) to 9.6 percent (SHARE).

We cannot have a little bit of competition and a little bit of deregulation, with government officials deciding how much freedom there will be. There must be a truly competitive model. This model must not have built into it artificial supports for one competing group over another. Each group must be prepared to accept the economic consequences of their decisions, keeping reasonable surpluses and accepting liability for losses. There can be no "bail out" for inefficient provider groups. Rather, Congress should concern itself with protecting patients from health care organizations that have faltered, and not protecting the organizations and the physicians practicing therein. This would provide marketplace pressures on health care organizations to make decisions about building or acquiring new technology based upon the economic consequences of such decisions, rather than through the regulatory process and certificate of need programs.

I have a strong conviction that any competitive model cannot be allowed to have selection of patients. All patients who elect this form of health care coverage must be covered. It is my understanding that the intent of Congress, at the time of passage of Medicare, was to insure the enfranchisement of all patients over the age of 65 through the Medicare program. We have now seen an example of the Medicare pre-payment experiment, which has allowed patient selection. This has resulted in a situation where plans are competing for the healthy patients, rather than competing to most economically provide services to a full range of patients. The residual patients who have not been allowed access to organized health care organizations (HMO), remain in the fee-for-service community, and are part of that group against which HMO's are being compared. This can only assure that one group of providing institutions and physicians is going to appear far more expensive than the other. Organizations must be required to compete for price with a like mix of patients. This may require either the establishment of risk pools of patients who are bad risks with their assignment equitably across competing organizations, or the offering of extra reimbursement incentives for the capitation of and provision of care for the high-risk or already sick/disabled individual.

I see the "selection of patients" problem as a transitional activity. If you establish a competitive health care model that is not directed at just a single group (Medicare), but at the entire United States population, then ultimately all patients will be acquired into various risk pools, and as younger people and their families are so acquired before disease manifestation, risks will become more equitable across all competing organizations.

I believe the National Health Care Reform Act of 1981 (H.R. 850) provides the comprehensive scheme which is necessary for competition to be introduced as well as expanding and equalizing Government help to people to participate in the system.

If you or your staff have any questions which I can help with, please let me know.

Sincerely,

RICHARD E. YADEAU, M.D.,
President.

STATEMENT OF ROBERT GUMBINER, M.D., PRESIDENT, FAMILY HEALTH PROGRAM, INC.

Although much lip service has been given to the competitiveness of HMOs, the fact of the matter is that the HMOs are not competitive. They are not competitive for the following reasons:

1. They are locked into benefits that are too high. Thus they cannot compete with insurance companies who come in with low benefits, particularly for the low-utilizing health care population which they must have to balance off the high using population.

Answer. Remove the mandated benefits. We have competed for 20 years in the field without having mandated benefits. Traditionally the HMO provides higher benefits but must be able to offer adjusted benefits that the employer and employee wants, not what government officials think they want through legislation.

2. The HMO is non-competitive in regard to obtaining physicians in the United States. This is because younger physicians can make unlimited amounts of money from third party payers who are unable to protect themselves, such as, Medicare, Medicaid, and insurance companies. No matter how many doctors are produced, the physicians, in general, go to high-paying surgical specialties whether they are needed or not and then make sure they do surgery on people, plus they (the physicians) go to metropolitan areas, particularly in the "Sun Belt". This still leaves us without the specialties needed in the HMO and in the geographic areas needed.

Answer. Give the doctor a tax credit or a tax advantage if they work for an HMO.

3. The HMO is viewed as a disadvantage to the employer (i.e., a disadvantage to enroll their employees in the HMO even though it is offered). This is because the employer perceives that the HMO has physicians and facilities that may not be acceptable to the employees and this problem will come back to them (the employer). In addition, it is just one more administrative chore. If they can keep people from enrolling in the HMO, they simply won't have those perceived problems. Besides, many employers have connections with insurance companies, particularly the large ones through inter-locking boards and financial arrangements, and want to continue good relations.

Answer. Make it a tax advantage to the employer for those people who enroll in the HMO. In other words, give them a bigger deductible for HMO enrollments than for non-HMO enrollments.

HMOs are only a temporary stop gap and partial solution to the competitive problem in the United States. We need to address: (1) the need for more doctors and specifically licensing doctors to go to areas in the specialties where they are needed, (2) designate what specialties will be produced, and how many, and what geographic areas they can go to.

STATEMENT OF LOUIS L. FRIEDMAN, M.D., LAS VEGAS, NEV.

Medicare and other government-supported rehabilitation and health programs are philosophically and morally correct. These programs are intended to provide readily available high-quality health services. Spiraling costs, however, are not only jeopardizing existing programs, but are also delaying implementation of much needed expansion of national health services. Cost of delivery must be controlled without compromising standards or diminishing the zeal of health providers. In accomplishing this objective the emphasis should be on ready availability to all citizens of high-quality health services. Piecemeal remedial measures will not address the problem. The entire system must be subjected to critical unbiased review before appropriate legislative changes may be suggested. Physicians should accept a cooperative responsibility in this effort. Certain glaring abuses and shortcomings, nevertheless, demand urgent attention and correction.

A sincere effort to limit hospital admissions is imperative. Preventative and expanded out-patient health services should be encouraged. Hospital admissions for any non-acute illness or medical emergency should require prior authorization. Utilization and audit reviews are costly time-consuming failures which do not effectively limit hospital admissions or the length of hospital stay. In-hospital services should be scrupulously avoided unless absolutely necessary. A graded patient financial responsibility schedule would be very helpful in accomplishing this goal. Patient pressure on the physician for hospital admission as well as out-patient services would be effectively relieved or at least diminished.

Medications and other therapeutic modalities should be made available to all government beneficiaries as an out-patient service based on the financial responsibility formula. This innovation will also assist in preventing unnecessary and avoid-able hospitalization. Prescription drugs should be limited to generic terminology and only those drugs approved by the Food and Drug Administration.

On the surface there appears to be over-utilization of emergency room and critical care unit services. New guidelines are needed. These units are staffed densely with the most capable and efficient personnel available. The basic needs of other less glamorous hospital areas are frequently ignored. As a rsult of this program of attrition, the quality of medical care may be substandard in the deprived units.

Hospitals participating in government health programs should be required to follow standardized bookkeeping and accounting procedures. The financial experience of each hospital should be kept separate from other hospitals in the same corporate entity. In many instances the emphasis on showing an annual profit has replaced dedication to excellent patient care and welfare. The availability of highly sophisticated x-ray and laboratory studies, do not necessarily contribute to good patient care. Quite frequently every available study is ordered without sufficient justification. Many hospitals are additionally burdened with the expense of oversized administrative departments of questionable training and capability. This bureaucracy generally specializes in studies designed to justify its continuing existence and the accelerating costs of medical services. In this atmoshpere patient welfare becomes a secondary consideration.

The Department of Health, Education and Welfare should elaborate and enforce appropriate hospital guidelines and standards. The government, in one way or another, pays a substantial part of all hospital costs. Accordingly, it should accept and not abdicate its responsibility for maintaining good hospital standards. The Joint Committee on Accreditation of Hospitals is ineffective. How can meaningful hospital inspections be performed when the subject hospital is informed two to three months ahead of time when to expect the inspection team? The rank and file of hospital personnel are never consulted. The inspection team sees and hears only what is planned.

Staff physicians and other paramedical personnel should be given a larger voice in hospital administration. A lot of sophisticated equipment and an annual profit do not necessarily reflect good medical standards. Physicians who participate in government sponsored programs should also be required to maintain standard recordkeeping procedures in order to facilitate ready transfer and referral of patients. Hospitals as well as physicians should not be permitted to advertise. This makes for hucksterism in medicine.

A meaningful effort should be launched to avoid duplication of patient services. For one reason or another patients change their preference for hospitals and doctors. Under these circumstances, recently performed expensive diagnostic studies are frequently repeated without justification. The provider of medical services and the patient each have a responsibiltiy to conserve the taxpayer's dollar. Physicians and patients should be dissuaded from accepting "Have government health insurance. Will travel." as a way of life. Government beneficiaries should have all pertinent medical information stored in regional computers. The information should be readily available to participating physicians and hospitals. This will avoid duplication of expensive services.

The government should organize a professional malpractice corporation to cover all physicians who render services to government beneficiaries. This program can be funded by adding a prorated premium contribution to all shysicians' fees. This would have the net effect of decelerating and diminishing the tendency to practice costly defensive medicine. Eact test, especially the very expensive diagnostic parametric studies, should be justified. Expenditures above certain levels should require prior authorization. It is possible for the government to watch the dollar while not interfering with good medical practice and standards. The easiest way to reduce the cost of medical care is to prevent unnecessary expenditures.

Physicians' Medicare fees should be standardized for the entire country. The present practice of fee differentials based upon regional reasonable usual and customary guidelines contributes to an over-abundance of physicians in those areas with high fee schedules and a consequent paucity of physicians in other areas of the country with lower fee schedules. Hospital-bnased/geographic physicians hould bill patients directly for their services.

GREATER SOUTHEAST COMMUNITY HOSPITAL,
Washington, D.C., October 8, 1981.

Hon. ANDREW JACOBS,
Chairman, Subcommittee on Health, Committee on Ways and Means.
House of Representatives, Washington, D.C.

DEAR CHAIRMAN JACOBS: I request that this statement be included in the record of your hearings on health care competition. I am President of the Greater Southeast Community Hospital in Washington, D.C. and Chairman of the Finance Committee of the D.C. Hospital Association. Greater Southeast has 450 beds and is the only full service Hospital for approximately 300,000 citizens of the District of Columbia and southern Prince George's County. About 18 percent of our patients are Medicaid beneficiaries; another 9 percent represent free care or bad debts.

I would like to emphasize my support for legislation which would reform the way health care is delivered and financed in this country.

The reasonable cost reimbursement system under which hospitals and doctors are presently paid by Medicare and Medicaid is not the appropriate method for the Government to channel its assistance to the poor and the elderly. Hospitals and doctors have no economic incentives not to provide care and at the same time government uses reasonable cost reimbursement to keep from paying its fair share of the costs of taking care of its beneficiaries and of the other costs of a hospital.

Some hospitals are able to make up the shortfall in Medicare and Medicaid reimbursement by increasing the amount they charge the charge-paying patients. The Government is thus being subsidized by commercial insurance and, in effect, transferring the cost of these patients to the charge-paying patient. But for hospitals, such as this one, which have a very low proportion of charge-paying patients, that is difficult to do. For every dollar by which Medicare or Medicaid fails even to pay costs, this Hospital must increase its charges by $5.00 just to come out even. Our financial stability and our ability to care for the poor are being threatened by the continuing cuts in Medicaid and Medicare.

We believe competition and deregulation are necessary because the system is being strangled by reasonable cost reimbursement and by its attendant regulatory apparatus. Hospital managers' ability to manage would be enhanced in a competitive and deregulated health care delivery system. It would provide the economic incentives which would enable us to organize more competitive and unified forms of care, joining doctors and hospitals in integrated units.

While I support competition, I think it is important to emphasize that competition cannot work, will not be fair, and will disadvantage the poor unless the Federal government provides adequate assistance to the poor and the elderly in obtaining health care. It is not doing so now. We are able to provide the care and barely to stay solvent by recouping some of the shortfalls in federal reimbursement from commercial insurance. But if commercial insurance becomes more competitive, we will not be able to do so. The insurance companies (or plans) will want to contract with hospitals which have the least shortfall in government reimbursement, so as to lower their prices. The result of this process could be that the hospitals caring for the poor and the elderly would—if those patients were not given an amount sufficient to pay for their care—lose the commercial business and would soon be unable to take care of the Medicare and Medicaid populations as well as the other poor citizens who are covered by neither Medicare nor Medicaid.

The National Health Care Reform Act of 1981 (H.R. 850) recognizes these problems in attempting to provide assistance in a competitive system to the Medicare and Medicaid beneficiaries, as well as to the working poor and other people who are not covered by health insurance through the tax credit mechanism. That bill is correct in bringing competition to the field and deregulating it, and, more than the other competition bills, it recognizes the need to improve federal assistance to the poor. It is an important step in the right direction.

We are, however, concerned, that in the transition period particularly, when we still are receiving Medicare and Medicaid reimbursement (and thus experiencing serious shortfalls), we would be unable to compete with other hospitals which did not have as many patients reimbursed under Medicare and Medicaid. Even after the transition period there could be a greater accumulation of bad debts in our Hospital than other hospitals in the area, which also would hurt our competitive situation.

We hope that in your deliberations on competitive bills, a mechanism will be included to ensure that the hospitals taking care of the poor and the elderly are not disadvantaged in a competitive system—either by providing adequate federal assistance or requiring other providers in the area to a contribute to a fund to offset the shortfalls.

The present system is not a good way to finance health care in this country in an efficient, responsive, and cost-effective way. I hope that when we switch to a new system, however, we not do so at the expense of the poor.

Sincerely yours,

DUNLOP ECKER, *President.*

HOSPITAL FINANCIAL MANAGEMENT ASSOCIATION,
Oak Brook, Ill., October 7, 1981.

Hon. ANDREW JACOBS, Jr.,
Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: The Hospital Financial Management Association (HFMA) commends you and the members of the Ways and Means' Subcommittee on Health for holding hearings on proposals to stimulate competition in the financing and delivery of health care. HFMA has a keen interest in the various legislative proposals to restructure the financing of health insurance and encourage cost restraint through the use of incentives to stimulate competition and greater cost consciousness. Therefore, we appreciate this opportunity to comment on these proposals for the record.

HFMA represents 20,000 individual members who are financial managers of healthcare facilities or who are closely associated with these activities. HFMA members are typically employed by hospitals, medical clinics, nursing homes, health maintenance organizations, management consulting firms, certified public accounting firms, law firms, and commercial and investment banking firms serving the healthcare field. HFMA was organized in 1946 and currently has 75 chapters nationwide.

HFMA members recognize that overregulation currently present in the healthcare field has not resolved and probably has contributed to the rate of increase in healthcare costs. Moreover, we recognize that basic structural reform of the present healthcare delivery and financing system is needed.

At the outset, then, we want you to know that we support the following public policy goals: The rapid growth of government regulation of the healthcare field, experienced during the past two decades, must be reversed; and the rate of change in public expenditures for healthcare services must be made more responsive to public priorities.

We endorse the following *broad principles* in support of the above goals:

(a) The financing of health insurance should be altered to encourage greater provider and consumer cost restraint and cost consciousness;

(b) The delivery and financing of healthcare services should be desinged to aid consumers to obtain efficient, medically appropriate and cost effective care;

(c) Technological and managerial innovation must be fostered;

(d) Appropriate financing methodologies must be devised to provide a steady flow of trained personnel adequate to current and projected needs;

(e) The role of the government with respect to the financing and delivery of health care should be to: (1) assure that all Americans have access to basic healthcare services, (2) provide rational economic incentives for consumers and healthcare providers, (3) assure fair economic competition among healthcare providers and health (insurance or service) plans in the private sector, (4) increase the ability of consumers to choose insurance strategies which are attuned to their own needs, and (5) create an environment that will encourage change in healthcare prices and expenditures to be more responsive to market influences,

(f) And, the role of the federal government should also: (1) make sure all regulatons are very clearly within the law and consistent with congressional intent, (2) emphasize private market forces when possible, (3) foster nationwide consistency while still allowing for flexibility to meet state and local conditions, (4) minimize government and private costs, (5) investigate and prosecute instances of fraud, (6) do away with unnecessary regulation not serving a compelling federal interest and reform those regulations which have not been implemented by the least intrusive means.

To *implement* these *broad principles,* HFMA favors:

Making the following changes in the *Medicare* program: (1) phase in greater beneficiary cost sharing, (2) replace the current retrospective "reasonable cost" reimbursement system operated directly by the federal government with realistic alternative payment systems for hospiitals, physicians and other institutional and individual healthcare providers, (3) transfer to private sector financing organizations a portion of the government's underwriting risk for Medicare beneficiaries, (4) bear a fair share of financial requirements related to charity services and bad debts,

(5) identify, measure and communicate financial responsibility in a manner which is more understandable to consumers, public and government, and (6) permit payment(s) which adequately consider market influences; and

(b) making the following changes in the *Medicaid* program: (1) identify, measure and communicate financial responsibility in a manner which is more understandable to consumers, the public and government, (2) adopt other principles described above for Medicare to the extent applicable to Medicaid beneficiaries.

In general, HFMA endorses the following goals:

(a) Provide incentives, by increasing cost-consciousness, for both, consumers and providers to utilize health services and resources most appropriately,

(b) Decrease the federal government's role in health decisions made by consumers, providers and insurers, and thus increase the freedom of these groups to develop more cost effective health delivery strategies,

(c) Promote cost-saving innovation in both management of health care delivery and the utilization of procedures and resources used in providing health care in order to achieve overall improvements in the efficiency and quality of the health care system.

In short, we favor:

(a) A total change in focus of regulation of the health sector,

(b) An increase in the ability of consumers to choose health insurance strategies that are attuned to their individual needs, and

(c) A rate of change in health care prices and expenditures which reflect consumer/public priorities, not bureaucratic decisions.

HFMA has given considerable attention to a new financial relationship between the health care industry and purchasers including the government. An article from the November 1980 issue of the Hospital Financial Management journal entitled, "Is Consumer Choice and Competition in Health Care the Wave of the Future?" is attached for the record. Three task forces of HFMA members are studying the competition/consumer choice issues and are identifying the criteria by which these proposals can properly be evaluated. We would be pleased to turn the attention of these groups to any specific questions that you may have. We appreciate this opportunity to share our views with you and the other members of the health subcommittee.

Sincerely,

James T. Whitman,
President.

[Additional material has been retained in the subcommittee files.]

IHP Corp.,
Oklahoma City, Okla., October 7, 1981.

Hon. Andrew Jacobs,
Chairman, Subcommittee on Health, Committee on Ways and Means,
House of Representatives, Washington, D.C.

Dear Chairman Jacobs: I am writing in response to your notice of hearings on the competition proposals and request that this letter be treated as a statement submitted to the Committee.

I am President of the IHP Corporation, a wholly owned subsidiary of Presbyterian Hospital in Oklahoma City, which operates seven hospitals in the State as well as providing consulting services to thirty-five other hospitals. As a hospital administrator, I have become all too familiar with the anomalous and perverse results created by reasonable cost reimbursement under Medicare and Medicaid and with the rigid and intrusive control of the health care delivery system which is being effected through the planning process and other pieces of regulation.

Reasonable cost reimbursement would not give hospitals enough money even if we were paid our actual costs of taking care of Medicare and Medicaid patients; it does not provide us the net income that all firms, including not-for-profit hospitals, need to stay in business. Since government does not pay even the actual costs of taking care of Medicare and Medicaid patients, the problem is far worse. We are able to remain solvent only because we have a sufficient number of patients who are indemnified by commercial insurance companies which make up the amounts that Medicare and Medicaid fail to pay for their own patients as well as the other costs or running a hospital which they do not recognize.

The pressures created by the reasonable cost reimbursement system are expensive. Under reasonable cost reimbursement, hospitals and doctors are rewarded for providing more care. Also, hospitals and doctors are on separate economic tracks. Doctors make the treatment decisions but hospitals bear the costs of them and a doctor need not be concerned about those costs.

A pre-payment system based upon competing price would require hospitals and doctors to form more cohesive economic units and introduce a cost factor into their decisions. It will provide a better way of allocating resources than the "Planning Act" can. The people who know most about care, that is hospitals and doctors, will have to decide whether or not the costs of providing new services or building new facilities are justified and whether patients will pay the price for them. But to make that work, patients must have an economic stake in their choice between competing plans.

This is a far more efficient and democratic way of making a decision than to permit appointed agents of the government to make that decision, which introduces a host of political factors.

If the structure of the system were changed by introducing price competition and by introducing cost sensitivity, hospital managers would be given the tools to do what I think society wants them to do—to organize new types of delivery systems which bring doctors, hospitals, nurses, and other allied health personnel together in true health care systems which would deliver care in a much more cost effective manner.

Given the proper incentives and the right tools, we can change the system. But if we continue under the present system, costs will increase at a rapid rate, and we will be fighting an endless regulatory battle with the government which will benefit no one—and certainly not the patient. We simply do not believe government is capable of making health care decisions for the people, as it is now by decreeing how many beds, CT scanners, or other pieces of equipment there should be in a community. Government's role should be limited to deciding how much it wants to give people for health care, and it cannot use that as a reason to control how health care is delivered. If its aid is used in a competitive system, in which its beneficiares have a reason to consider the price of care, it would not need to control the system.

I strongly urge the Committee to give favorable consideration to efforts to reduce regulation and increase economic competition and accountability in our field. H.R. 850 would introduce the right incentives into the field, permit hospital managers to do their job, and make everyone in the field more cost-conscious. It is far preferable to the present system and to the other alternative—"cost containment." Some hospitals will have problems in adjusting but the public interest requires that providers compete and that government regulation be lessened.

Sincerely,

BRUCE M. PERRY, *President*.

STATEMENT OF RUTH WATSON LUBIC, GENERAL DIRECTOR AND ASSISTANT SECRETARY, MATERNITY CENTER ASSOCIATION, NEW YORK, N.Y.

Maternity Center Association (MCA) is a 64 year old national voluntary health agency which seeks to improve maternal and family health through mounting demonstration projects which, if proven, can be adopted by the in-place health care delivery system. Included in MCA's past accomplishments are models of prenatal care (1917), nurse-midwifery education (1932) and prepared childbirth (1948).

MCA's latest demonstration, the Childbearing Center (CbC), was set up because of the desire of segments of the childbearing public for alternatives to conventional maternity care. They consider in-hospital birth to be illness-oriented, managed with inappropriate and excessive technologic intervention, unresponsive to the emotional and spiritual needs of families and high in cost. The Childbearing Center is a free-standing, out-of-hospital center for families anticipating a normal pregnancy and birth. The CbC has been operating for 6 years now; over 1000 births have taken place in-house. The CbC has been monitored for safety and fiscal experience by the New York State Health Department and Blue Cross/Blue Shield of Greater New York. The unit is accredited by the National League for Nursing/American Public Health Association. I have attached a recent reprint on its experience. This past Spring, MCA received a grant from the John A. Hartford Foundation in part to facilitate a network to assist the estimated 125–150 birth centers in 27 states now open or in process of opening. (press release attached.)

Although the primary objective was to provide care which would entice families away from "do-it-yourself" homebirth, many have been impressed with the savings the center provides both families and the health care delivery system. In 1980 the CbC was self-supporting at a comprehensive fee of $1,000 while private normal maternity care in New York City was quoted at $2,250 to $5,000 and cesarean section at double these figures, in the New York Times. (attached).

In addition, CbC care saves the Medicaid program in New York from $855 to $1,840 per normal birth. If one assumes similar savings nationwide, the figures are compelling. For example, based on 1980 NCHS natality statistics (3,598,000 births),[1] If 25 percent of women wanted and had access to such care—conservatively 75 percent would be physically eligible—from $769,072,500 to $1,655,080,000 could be saved. If 50 percent of families could be cared for in such facilities, savings of over three billion dollars annually would be realized, based on CbC experience.

In spite of the above and the fact that this model was conceived and implemented entirely on private voluntary initiative, is highly prevention and education oriented, provides great satisfaction to families, and has been sought by families and replicated nationwide, I have had difficulty in obtaining the interest of the administration beyond a suggestion that we do a cost benefit study. Delay and costs aside, such a study would be very difficult if not impossible to do because of the lack of existence and/or accessibility of comparable in-hospital figures. It is my impression that the cost of in-hospital care can only be estimated and therefore that fees charged have indeterminate relationship to actual costs.

This brings me to the topic of competition in health care delivery. In our opinion, competition in the marketplace assumes equal access to consumers. MCA's experience is that innovative units such as the CbC, staffed by nurse-midwives with obstetrical, pediatric and public health nurse backup, do not have that access on two levels. First, the opposition of organized medical groups expressed itself in attempts to prevent and revoke our licensing by New York State and also to prevent access to reimbursement, both private and Medicaid. I refer you to my testimony before the Subcommittee On Oversight and Investigations of the Committee on Interstate and Foreign Commerce, House of Representatives, 96th Congress, Second Session, December 18, 1980, Serial No. 96-236 pp. 72-89.

Secondly although demand for alternatives has prompted the replication of our unit, there are many too few nurse-midwives produced each year to provide staffing. Consider that the appropriation being discussed for the entire Nurse Training Act, through which all nurse practitioner programs are funded, is about 1/15th of the smallest amount of potential savings provided by nurse-midwives as quoted above. It becomes apparent that the Congress needs to facilitate the remarkable competitive potential of nurse-midwifery care through eliminating restraint attempts and providing support for the education of nurses to become midwives.

For your information, I have enclosed documentation of the Medicaid rates quoted. If I can provide any further information to the Committee, I would be more than happy to do so.

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[1] National Center for Health Statistics Monthly Vital Statistics, Provisional Data, Volume 29, No. 13, Sept. 17, 1981.

MEDICAID REIMBURSEMENT FOR NORMAL CHILDBIRTH

HOSPITAL	OUT-PATIENT VISIT Prenatal* or Postpartum	PER DIEM IN-HOSPITAL RATE			TOTAL COST TO MEDICAID			TOTAL COST TO MEDICAID		
		Mother	Infant**	Total	10 Out-Patient Visits	3-Day In-Hospital Stay	Total	10 Out-Patient Visits	4-Day In-Hospital Stay	Total
Lenox Hill	$63.58	$354.11	$118.04	$472.15	$635.80	$1416.45	$2052.25	$635.80	$1888.60	$2524.40
Metropolitan	63.23	346.90	115.63	462.53	632.30	1387.59	2019.89	632.30	1850.12	2482.42
Mt. Sinai	64.68	407.96	135.99	543.95	646.80	1631.85	2278.65	646.80	2175.80	2822.60
St. Luke's	62.72	351.27	117.09	468.36	627.20	1405.08	2032.28	627.20	1873.44	2500.64
Columbia	63.90	375.39	125.13	500.52	639.00	1501.56	2140.56	639.00	2002.08	2641.08
St. Vincent's	63.02	343.52	114.51	458.03	630.20	1374.09	2004.29	630.20	1832.12	2462.32
Roosevelt	62.72	351.27	117.09	468.36	627.20	1405.08	2032.28	627.20	1873.44	2500.64
N.Y. Hospital	62.04	393.73	131.24	524.97	620.40	1574.91	2195.31	620.40	2099.88	2720.28
Beth Israel	67.69	364.16	121.39	485.55	676.90	1456.65	2133.55	676.90	1942.20	2619.10
N.Y. University	44.57	390.39	130.13	520.52	445.70	1561.56	2007.26	445.70	2082.08	2527.78
North Central Bronx	70.11	400.96	133.65	534.61	701.10	1603.83	2304.93	701.10	2138.44	2839.54
Bellevue	68.86	303.19	101.06	404.25	688.60	1212.75	1901.35	688.60	1617.00	2305.60
Harlem	63.01	306.22	102.07	408.29	630.10	1224.87	1854.97	630.10	1633.16	2263.26

*Ten prenatal visits are considered to be optimum. In addition one postpartum visit is scheduled.

** The rate for an infant in the normal nursery is 1/3 the adult per diem rate. The rate for an infant in the neonatal intensive care unit is the same as the adult per diem rate.

SOURCE: State of New York, Office of Health Systems Management, HEALTH FACILITIES MEMORANDUM:

1) Series 81-17, Date 3-18-81; Subject: Hospital Inpatient and non-28A Hospital Based Residential Health Care Facility Reimbursement Rates of Payment for the Period January 1, 1981 through December 31, 1981.
2) Series 81-64 Hospital Outpatient Reimbursement Rates of Payment April 1, 1981 through March 31, 1982.

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September 30, 1981

ECONOMIC ASPECTS OF THE CHILDBEARING CENTER

Introduction

Maternity Center Association's Childbearing Center (CbC) was designed and implemented to demonstrate whether safe, satisfying and economically reasonable care could be provided to a carefully screened, healthy childbearing population. In the opinion of MCA's expert advisory committees, the New York State Health Department and Blue Cross/Blue Shield of Greater New York, safety has been demonstrated during the CbC's six years of operation insofar as it can be shown with a relatively small number of births (1,000 total births in-house). The satisfactions of families have been recorded in letters and evaluations from those utilizing the Center. The Center is accredited by the National League for Nursing/American Public Health Association. The economy of the concept is discussed below.

Blue Cross/Blue Shield of Greater New York Findings

A fiscal audit for the years 1976-77 reported in January 1979 by Blue Cross/Blue Shield of Greater New York sets forth the information that charges for Childbearing Center care are 37.6% of in-hospital care, barring complications. The audit report also noted that the Cost to BCBSGNY for families delivered at the Center is 66.1% of the cost to the plan had the same family gone to a hospital setting, also barring complications. Subject to annual review of our services, BCBSGNY has reimbursed to families our full charges (currently $1,000). Charges are based upon projected costs at full operation and represent the figure necessary for the CbC to be completely self-supporting. (BCBSGNY in 1979 extended the review period to three years.)

To ensure safety, the CbC was staffed from its opening in late 1975 as though it were in full operation. As a result, the actual costs of full care during 1976, 1977, 1978, 1979, and 1980 were $2,016.46, $1,795.00, $1,213.23, $1,046.17, and $1,024.58 respectively. The first two figures were derived by BCBSGNY; the latter three by MCA, based on internal audits. MCA expected that running-in costs would exceed income and has absorbed the deficit. During 1978, the CbC's 1977 operating deficit was virtually cut in half because of operating refinements and increased utilization by families. MCA's prediction for self-support, 600 families in program annually, proved both accurate and achievable in 1980 when 436 new families enrolled.

The Medicaid Program

It is interesting to compare CbC charges of $1,000 with Medicaid reimbursement for in-hospital normal maternity care, as shown in the attachment. In a representative group of hospitals, Medicaid is currently paying from $1,854.97 to $2,304.93 for normal maternity care with a total three-day hospital stay, or approximately $855 to $1,300 more than MCA charges. For a total four-day stay, the surplus over MCA's charges varies from approximately $1,265 to $1,840. As can be seen, the out-of-hospital concept promises the Medicaid program marked savings.

The Economic Aspect

The care that is provided at the homelike Childbearing Center is oriented toward prevention and toward including families as much as possible as members of the decision-making team. To some it appears that because there is not a three or four-day hospital stay, the traditional in-hospital and MCA's out-of-hospital program cannot be considered to be equivalent in quality. It is MCA's position rather that presence in a hospital setting does not guarantee contact time with qualified professional staff. At MCA a high quality of care has been achieved through carefully educating families and incorporating them in their care at all phases of the maternity cycle. Care during labor and delivery is constant and individualized. Further, because they are not separated from their infants, CbC parents actually have more contact time with their infants than a traditional hospital stay provides, and all family/infant contact is supervised by nurse-midwifery staff. A pediatric specialist examines the infant in the presence of the parents before they return home. Traditional hospital oriented management, whether private or clinic, does not begin to provide such professional contact time.

Further economies have been realized through the utilization of non-hospital space as the setting for the functioning of a professional team consisting of nurse-midwives with obstetrical and pediatric consultation, In short, we coordinate families, personnel, equipment and setting in an appropriate manner for healthy normal childbearing, while having made allowances and arrangements for the safe care of those whose progress becomes complicated. The extensive in-depth educational program which emphasizes nutrition, family relationships and self-help/self-care is included in our charges. The home, to which a family returns in 12 hours following birth, is also utilized as a setting for postpartum care. Two visits are made to families by public health nurses during the first five days of the infant's life and two visits are made to the Center by families during their postpartum period. Unlimited telephone consultation is available. All of this in included in the comprehensive fee of $1,000.

For all these reasons, MCA maintains that its care is superior in quality to that provided in the traditional hospital setting for which Medicaid is reimbursing. Private care (hospital plus obstetrical fees) for normal childbearing in New York City is reported in the December 18, 1980 New York Times as follows:-- ..."The costs of prenatal care and normal delivery have risen dramatically; in Manhattan they now range from $2,250 to $5,000." (copy attached)

Conclusion

MCA submits that Childbearing Center care is markedly less expensive than traditional hospital care for both families and the health care delivery system, while at the same time providing safe, high quality, personalized maternity care.

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COMMENTS FROM CHILDBEARING CENTER FAMILIES

"Although the Maternity Center provides an outstanding service for parents, I think the significance of this work is not restricted to the medical sphere. All of the institutions of American society, whether they are governmental, educational, or medical, are plagued with problems of bureaucratic incompetence and human insensitivity. It is clear to me that the Maternity Center Association is pioneering a new direction for the evolution of American society in which small institutions are able to decentralize from the giant ones so as to provide services in a human environment. The fact that the Maternity Center Association is not opposed to larger institutions, and where it is appropriate, it cooperates effectively with the Lenox Hill Hospital or Columbia University, is to me a significant model for institutional decentralization in the future. For example, small centers for the dying could be established in which death would take place in a family setting, just as birth takes place in a family setting at the Maternity Center."

"Childbirth is for me one of, if not the most, profound experiences in this universe. Unfortunately, it can be handled in a myriad of ugly and insensitive ways, and so often made empty or unpleasant, or worse. Louis' birth in 1974 was, as hospital births go, a good one, and the four hours I waited to see him again after the initial half minute or so of holding him in my arms on the delivery table was, I understand, a shorter than average time. But I have regretted those four hours all of his life. And hearing the babies cry in the rooming-in nursery between night feedings and during visiting hours was very trying for me. I wanted my child with me from the moment of his birth, and it seemed to me that the hospital and my cold, wise-cracking doctor were crazy not to understand and honor a mother's instincts.

"I also felt emotionally weak and a failure after my first delivery because I hadn't remained in control throughout my labor and had begged for and been given drugs to relieve pain."

In contrast, this is the way the same mother felt about her experience in the Birth Center:

"This time, I made it through labor without any chemical crutches (indeed, without uttering a single self-pitying or angry word!) Again, there is no way to tell you how important this has been to me. I feel that having faced my labor with dignity is a fact that will bolster my image of myself for the rest of my life. It was a gift not only to me, but to all those close to me. It's made me a stronger, more confident person.

"I'll never forget the beautiful way my labor was conducted. When we arrived at the Center it was close to midnight. After being checked, I sat on the big, comfortable rocker outside the examination room next to my husband and a good friend. We had a poignantly pleasant, flowing conversation (which I faded out of during the contractions, but had no trouble re-entering) until maybe ten minutes before my daughter was born. How simple and calm it all was! I spent most of my first labor whining and complaining, reduced to a helpless child in a useless quest for sympathy and understanding. This time I had known for months that I would be given these things without asking. I was not afraid; I was not alone. It was something I wasn't even consciously aware of. Only afterwards did I realize how powerful was the effect of those lovely women on my ability to be responsible for myself. It never entered my mind to ask for drugs; their peaceful good humor and interest were balm enough for my discomfort.

"And Louis, who by the time the baby was due looked forward to our trips to the "Ternity Center", had a fine time the day Eve came. When most kids are confused and bereft, he was being waited on hand and foot by people he'd grown to like and trust over more than half a year. And, of course, he had his mother around (I was sitting beside him on the couch in the family room, when he woke, to take him to meet his sister). I'm certain that this way of introducing him to his sibling greatly reduced the tension, anger, jealousy and hurt inherent in this "primal" situation.

"In short, we all left your establishment 'untraumatized'. Interestingly, I've had no 'blues' whatever, and the baby was almost immediately assimilated by our family.

"You gave us the invaluable gift of a happy pregnancy and a blissful birth. I don't see how a venture like yours can fail to proliferate, and for the sake of mothers (and babies and siblings and fathers) to-be everywhere, I fervently hope that it does."

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Addendum

Late in 1979 the Childbearing Center of Maternity Center Association was accredited through a joint program offered by the National League for Nursing/American Public Health Association. At about the same time, in order to achieve the goal of self-support for the CbC, fees were increased from $850 plus a $35 charge for deferred payment handling to $1,000 plus $45. The Childbearing Center operated in 1980 on a budget of approximately $325,000.

Actual expenditures break down percentage-wise as follows and include:

A: 72% - STAFFING

5-1/2 staff nurse-midwives (including administration)
4-1/2 staff nurse-midwife assistants
3 consultant obstetrician/gynecologists
(12 hour/week in-house office hour coverage plus 24hr/day telephone consultation)
2 pediatric consultants (one exam each infant)
1 full-time administrative assistant
2 part-time housekeepers

B: 14% - CLINICAL COSTS

clinical supplies
contracted services (laboratory, visiting nurse service, laundry, beeper, ambulance)

C: 6% - ADMINISTRATIVE SUPPORT

bookkeeping, accounting and legal
local travel
malpractice insurance
office supplies and printing
telephone and postage

D: 8% - BUILDING OCCUPANCY

gas and electric
maintenance contracts
replacement and repair of equipment
insurance
rent (allocated at $20,000)

REIMBURSEMENT

All families except those eligible for Medicaid pay their fees directly and in advance of birth; in that sense they are self-pay. Most have insurance coverage with private carriers. A special agreement with Blue Cross/Blue Shield of Greater New York provides their contract holders with reimbursement of full charges so long as they do not exceed costs. Separate provider reimbursement was not sought. MCA assists families in preparing forms; checks are remitted directly to contract holder. It is MCA's experience that other private carriers follow the lead of Blue Cross. Medicaid reimbursement is currently at the $1,000 figure.

THE NEW YORK TIMES, THURSDAY, DECEMBER 18, 1980

The Rising Costs Of Having a Baby

By DEBORAH RANKIN

NOTHING is immune from inflation these days, not even having a child. The costs of prenatal care and normal delivery have risen dramatically; in Manhattan they now range from $2,250 to $5,000. A Caesarean delivery, which requires a much longer hospital stay for the mother, can double the bill.

"It's a lot of money," said James H. Brennan Jr., a vice president of Towers, Perrin, Forster & Crosby, an employee benefit consulting firm that counsels many large companies on various types of fringe benefits, including maternity coverage. "All the costs of childbirth have gone up enormously in the last few years."

Although maternity costs in other areas are generally less than in Manhattan, obstetricians acknowledge that their fees have been rising along with the general price level in the economy. But observers say that the increases in obstetrical and related hospital costs have been less rapid than in other areas of medicine, such as burn treatment, where there have been costly technological advances.

Dr. Stanley Zinberg, Manhattan section chairman of the American College of Obstetricians and Gynecologists and associate professor of obstetrics and gynecology at the New York University Medical Center, said that the average obstetrician's bill in New York ranges from $1,200 to $1,500, although some physicians charge close to $2,000 with no apparent loss of business.

He points out that the fee typically covers an initial consultation, 10 to 15 office visits, as well as the doctor's presence at delivery, "regardless of whether it's long or short, vaginal or abdominal." The bill covers "fairly rigorous phone availability," he said, as well as postpartum care in and out of the hospital.

Many physicians, he added, make no additional charge if they perform an amniocentesis — a procedure that extracts some of the amniotic fluid from the mother to determine if the fetus suffers from Down's syndrome. However, there are separate laboratory fees for analysis of the fluid.

Dr. Zinberg believes that the wide range of services provided justifies the average obstetrician's bill in the city, but that the general public seems to have an easier time accepting a similar charge for a single surgical procedure, such as hysterectomy. If anything, he said, obstetrical fees have been kept "artificially low because you're dealing with younger people who can't afford a big bill, and usually get inadequate insurance reimbursement."

Dr. Mordecai A. Berkun, medical director of Blue Cross-Blue Shield of Greater New York, said that the company's most popular insurance contract covers only $300 of obstetrician charges for a normal delivery, even though the typical bill is much higher. The company's top-of-the-line contract will pay "somewhere close to $725," he said, but it is not widely used.

Mr. Brennan said that most of the companies counseled by his consulting firm have more generous insurance coverage, and pay 75 to 80 percent of the costs.

In any case, the costs of the mother's hospital maternity stay — so long as it is not excessive — are usually covered in full by most insurance plans. The typical stay for a normal delivery is three to four days, and in Manhattan costs anywhere from $1,500 to $3,000. In addition to the mother's care, including labor and delivery room fees, this also covers nursery fees for the baby. A Caesarean delivery usually entails a hospital stay of eight to 10 days; "I wouldn't be surprised if the bill came to $5,000," said Dr. Zinberg.

These are the basic costs — there are also the less obvious, but significant costs of outfiting the expectant mother and purchasing a layette and nursery equipment for the new baby, plus the long-range costs that encompass everything from pediatrics to orthodontics treatment, summer camp, baby sitters and college.

Inflation has affected the cost of maternity clothes, along with other items of apparel. One pregnant career woman who felt she already had a fairly complete maternity wardrobe from the birth of her first child 18 months earlier visited a popular maternity store for a few supplementary items and was astonished when the bill came to close to $200.

"All I bought was a jumper, a pair of slacks, a T-shirt and some lingerie," she said. "The slacks literally fell apart after the first washing, and I was flabbergasted that maternity support hose at $7.50 a pair run every bit as quickly as the $1.59 variety from the supermarket."

Another working woman who is expecting a child reports that as her pregnancy progresses, she is resorting to expensive forms of transportation because of her increasing exhaustion. "Now I take the subway when I used to walk, and take cabs when I used to take the subway," she said.

Because of the woman's fatigue or sudden dislike of her former diet, many couples find themselves frequenting restaurants more, or resorting to carry-out food. Other women develop a craving for luxury food items. One suburban matron said that in the early months of her pregnancy, the only meat she could abide was loin lamb chops.

These expensive food cravings don't necessarily go away after birth. One mother who is breast-feeding her child reports that when she started nursing, she suddenly developed a taste for beer, a drink she had not touched since college. But no domestic brew would do; it had to be imported dark beer. "My husband says it would be cheaper to put the baby on formula," she said.

[Press release from Maternity Center Association, May 6, 1981]

NEW PROGRAM SUPPORTS DEVELOPMENT OF LOW-COST BIRTH ALTERNATIVES

A new program to aid the development of low-cost maternity care in birth centers is being launched by Maternity Center Association, a New York-based national voluntary health agency. Designed to promote an alternative to the traditional hospital setting, the program is supported by a grant of nearly $256,000 from the John A. Hartford Foundation, also located in New York City.

According to Ruth Watson Lubic, MCA's general director and a certified nurse-midwife, the new program builds on the Association's experience with its own Childbearing Center, a demonstration out-of-hospital unit that opened in the fall of 1975. The first of its kind in the United States, the unit offers a complete maternity service, including prenatal care and prepared childbirth classes, to families anticipating a normal pregnancy and birth. Care is provided by a team of nurse-midwives, obstetricians, pediatricians, parent educators and other supporting staff.

Since it opened, Dr. Lubic said, nearly 900 births have taken place there at a cost to families "substantially below" that of birth in the hospital. The results have shown that it can serve as a model offering a "safe, satisfying and economical alternative to hospital care."

The model has generated widespread interest among health care professionals and consumers in the United States and abroad. In recent years, some 74 birth centers have opened in 26 states, with at least 20 others in the planning stage.

Despite this demonstrated success, Dr. Lubic said, a number of obstacles threaten future birth center growth. These include the lack of state standards and regulations governing birth centers, the lack of comprehensive reimbursement plans by some insurance carriers, and the lack of a clear understanding of the concept on the part of both professionals and the general public.

With the support provided by the John A. Hartford Foundation, the new program will directly address these problems. Dr. Lubic described three major areas of activity for the coming months: The development of a manual of birth center standards for the guidance of public health officials, policy planners and insurance carriers; the creation of a cooperative resources and information network for dissemination of the model at the operational level; and the promotion of wider public understanding of the birth center concept.

She said that several meetings have already been held with birth center representatives from around the country. In addition, an initial cooperative research project is nearing completion. Begun last year, it is a collaborative study of a sample drawn from a total of nearly 4,000 births at 11 U.S. centers, comparing these results with those in a national sample of hospital births. The study also describes the medical and demographic characteristics of mothers in the study sample. A final report of the research project is currently being prepared for publication.

MCA President Mrs. Philip W. Farley noted that the grant for the new program enables the Association to continue its 63-year tradition of innovation in maternity care. "This has been our role in prenatal care, nurse-midwifery education, prepared childbirth and family-centered maternity care," she said. "Now, thanks to this impressive grant from a foundation of national stature, we can move forward with the birth center concept."

The John A. Hartford Foundation makes grants to stimulate health care payment system reform and to promote efficient energy use. It also sponsors a fellowship program for early career support of physicians in medical research.

The grant to Maternity Center Association, part of the foundation's program in health care payment system reform, provides a total of $255,975 over a two-year period.

[Additional material has been retained in the subcommittee files.]

THE MEDICAL SOCIETY OF VIRGINIA,
Richmond, Va., October 9, 1981.

Hon. ANDY JACOBS,
Chairman, Health Subcommittee,
House Committee on Ways and Means, Washington, D.C.

DEAR MR. JACOBS: As Chairman of the Vanguard Committee of the Medical Society of Virginia, I would like to submit the attached report, outlining our preliminary concerns regarding the current "pro-competition" proposals, for consideration as a part of your subcommittee's review of the "pro-competition" concept.

Charged by the Medical Society of Virginia with the responsibility of evaluating federal legislation and regulations pertaining to the health care field, the Vanguard

Committee has undertaken a review of H.R. 850 which appears to be representative of the "pro-competition" proposals currently before the Congress.

This report expresses concerns over the proposed broad and excessive powers granted to the Secretary of Health and Human Services under the legislation and recommends amending this legislation in one of two ways: (a) Eliminating entirely those powers to be granted to the Secretary of HHS or; (b) If such powers are granted, limiting them to those patients who are federally funded.

We believe that such alteration would then eliminate extension of unnecessary interference by the Secretary of HHS and the Congress into health care plans which are privately financed.

Your Committee's consideration of these particular aspects of the current proposals would be greatly appreciated and, indeed, of great benefit as the "pro-competition" concept is further defined and revised.

Sincerely,

HARRY C. KUYKENDALL, M.D., FAAFP,
Chairman.

PRO-COMPETITION: A REPORT OF THE VANGUARD COMMITTEE OF THE MEDICAL SOCIETY OF VIRGINIA, HARRY C. KUYKENDALL, CHAIRMAN

FOREWORD

In mid 1980, the Vanguard Committee reported briefly to Council on the "pro-competition" bills being advanced in the Congress. In November, recognizing the potential impact of such bills, but not having the knowledge necessary to advise the Society properly, the Committee submitted for House approval a recommendation which resulted in the attached Medical Society of Virginia resolution to the AMA.

In February, AMA's Board of Trustees published an analysis of the competition bills and concluded that the radical restructuring of health care called for in the bills deserved strong opposition and judged them not amenable to alteration.

The Vanguard Committee concurred in AMA's analysis but felt that the enormity of the possible impact of the bills, coupled with the evident momentum behind them, necessitated our own detailed investigation and the widest possible dissemination of our summary findings to the Society's membership.

Intense effort by a subcommittee of Vanguard has taken place over the last several months. The subcommittee considered briefly all "pro-competition" bills[1] but, for the sake of simplicity, reserved specific comment here only to H.R. 850, the Gephardt-Stockman bill (revised version of H.R. 7527, last year's Gephardt-Stockman bill), as the prototype and most comprehensive so far advanced. It should be noted that the 1980 bill of Ullman, et al., will likely be reintroduced and, more significantly, still another "pro-competition" bill is in the early development stages by the Administration. No Congressional action is expected in this session of Congress, although hearings on at least one bill (Durenberger's) are anticipated this fall.

Finally, it should be noted that the subcommittee has and will continue to discuss and coordinate its efforts with AMA and with other concerned bodies insofar as it is feasible.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 60 (1-80)
Introduced by: Virginia Delegation
Subject: Stockman-Gephardt Reform Act of 1980
Referred to: Reference Committee B (Raymond Scalettar, M.D., Chairman)

Whereas, The Stockman-Gephardt Health Care Reform Act of 1980 recognizes the deficiencies and excesses of over-control of the medical profession and the health care industry in general; and

Whereas, The act proposes incentive initiatives in a privately structured and operated health care system for the United States; and

Whereas, The institution of the act would entail the diminution, negation or repeal of "reasonable cost reimbursement" requirements, residual Hill-Burton constraints, Health Systems Agencies, Professional Standards Review Organizations, Medicaid and Medicare; and

Whereas, The act may take inadequate account of quality assurance, sliding-scale subsidization according to need and other matters of concern; therefore be it

Resolved, That the American Medical Association devise amendments which might enable the profession to support all or part of the more laudable features of

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[1] In the Senate, Hatch's S. 139 (old Schweiker S. 1590) and Durenberger's S. 433; in the House, Gephardt-Stockman H.R. 850.

HR 7527 (Stockman-Gephardt Health Care Reform Act of 1980) which recognizes the deficiencies and excesses of over-control of the medical profession and the health care industry in general and proposes incentive initiatives in a privately structured and operated health care system for the United States.

THUMBNAIL EXPLANATION OF BILL

For employers who wish to offer health care coverage to employees, the bill would have the Secretary of HHS determine, annually, a maximum amount of deductible money which could be spent. Employees who wish to participate would have an equal sum declared deductible and the total would be used by the employee to purchase coverage in a pre-paid health plan for that year.

The pre-paid plans would compete for the employee by offering lower deductibles, more extended coverage, cheaper prices, better facilities, etc. If the employee chooses a plan less costly than the amount allowed, he would be entitled to receive the difference himself, tax-free. If he chooses a more costly plan, he must pay the difference with taxable dollars.

These selections, however, would be limited to plans which the Secretary deems to be "qualified" and whose qualifications must include a "catastrophic" provision, certain "basic" medical care services, bankruptcy insurance and a number of other particulars.

Medically indigent persons (presently subsidized by federal programs such as Medicaid, Medicare and Title XIX) would be provided with federal vouchers of an equivalent value to the deductibility limits for that year with which, again, to shop for and purchase a pre-paid plan, and again, receive any difference as a tax-free bonus.

Self-employed persons would, likewise, receive vouchers and tax subsidization.

Anticipation of decreased total health costs lies principally in the belief that the "health maintenance organization" (HMO) concept is a cost-saving mechanism in itself and that such savings, translated to lower premium costs, will capture increasingly larger segments of insurance-buying citizens. The bill thus anticipates (but does not mandate) proliferation of HMO-type plans which, by way of profit incentives to providers, tend to minimize utilization of facilities and services and would, over time, reduce the total health care dollars expended. Proceeding on that premise, the bill anticipates that current programs of Medicaid, Medicare, Hill-Burton, etc., and their resultant offspring (e.g. PSRO, HSA, cost containment, etc.) would become superfluous, and thus, the bill calls for repeal or dismantling of these programs and others.

DISCUSSION

The most commanding problem with these bills is the expansion of federal subsidization and control to encompass the entire population and the entire health care system of the country; i.e., it is a budding "national health insurance" proposal and should be construed as nothing less.

It is curious to think that the authors of the bill and its preamble, which so eloquently cite governmental controls as the major factor in escalating health care costs, do not perceive as great a ferfidy inherent in their commitment to coercing the restructuring of the private health care delivery and financing systems.

From the purely fiscal point of view, the HMO concept, where providers are themselves at financial risk and where tight, often constricting, utilization controls are in place, offers palpable incentives to providers not to "spend" the pre-paid monies of the plan for needless or extravagant services and, thus, to recover a larger amount of the surplus at year's end. To whatever degree providers may at present tend to over-utilize because of profit incentives, those same providers would be expected to under-utilize for the same reason, if the profit incentive is reversed. An integral part of any conviction that HMO's will lessen health expenditures resides in the conviction that over-utilization is presently widespread and expanding, and is due, in the main, to provider profit seeking.

To whatever degree, then, that altruism exists with providers, that level of acceptability to the HMO concept should be found, and indeed, MSV and the AMA are both on record as approving pluralism in health care delivery and financing, so long as subsidization does not unfairly favor one system over another.

It is important to remember here that, although H.R. 850 would neither subsidize nor mandate the HMO mode, it would alter the tax laws to decree that health insurance premiums would henceforth be deductible only if used for plans approved by the Secretary of HHS. Although Secretarial approval at present requires quite reasonable criteria, there is little to prevent (and, in fact, one might expect) subsequent amendment of those criteria to more perfidious levels. Even without such changes, however, it appears extremely inappropriate to vest the Secretary with such discretion over the general population when it is clearly superflous and, moreover, reintroduces the question of fiscal coercion into the entire matter. On this particular point, we would differ from the AMA analysis which, by concurring that plans should contain "minimum benefits," overlooks the fact that such approval would constitute a tacit endorsement of abrogating control of private insurance to the Secretary of HHS.

Were H.R. 850 merely a proposal to encourage an alternative system of delivering and financing the health care of those people already defined as federal wards (and already being financed with government money) one might be more apt to concede the right of government to pursue what it believes to be a "better way." The case might be made that, so long as medical facilities and practitioners accept government money for the case of such persons, the government might be privileged, or even obligated from both the moral and fidiciary aspects, to exert significant influence over the quality and quantity of the care that is delivered and the manner in which it is financed.

In the context of such a limited application, the competition approach might then be not altogether off the mark, although even then a number of substantive modifications should most certainly be made in any of the bills which have appeared to date.

It is this latter approach that the Committee believes should be explored; i.e., to narrow the scope of the proposal to be applicable only to those segments of the population whose health care is already being paid for with federal money. This bill, with alteration of several lesser particulars, would then be a proposal fostering, but not mandating, a greater pluralism in health care financing as a cost saving effort for the care of "federal" patients only. Should the Congress so desire, such an approach would not be altogether irrational or signally destructive to the nation's present health care system. Moreover, should it work and pre-paid concepts prove, in fact, to be a "better way," the rest of the non-subsized population would, in time, surely follow suit anyway without the need for any legislation or tax coercion to bring it about.

It must be borne in mind in this discussion that the term "prepaid" as used in this bill includes, but is not limited to, the HMO mode: i.e., it refers equally to the more traditional third party insurance modes of the Blue Cross/Blue Shield plans, et al., and thus it does not represent a bill to favor HMO plans per se, although proponents of competition foresee the rapid emergence of HMO's as the dominent health care delivery mode if there is unimpeded competitive opportunity. Such conclusions themselves warrant a discussion as well, but it has been consciously omitted in this presentation as premature to the approach which the Committee believes should be initially considered.

The Committee views this as the outline of a previously unstated response to H.R. 850 and the pro-competition philosophy. Implementation of such a response would require a greater specificity than is contained here and the Committee is prepared to offer greater detail, but in no way would be capable of authoring the necessary amending articles per se—the Committee does not have the means to "rewrite the bill."

CONCLUSION

The Committee believes that the current prominence of the advocates of competition in Washington and across the country establishes that the Society is not forgiven the responsibility for comprehending and responding to the precepts involved. Powerful support by the federal government, the largest single health dollar payor, and significant elements of industry, the second largest, cannot be ignored and mandates that all possible avenues of approach be examined.

We, therefore, suggest that the Medical Society of Virginia consider calling for amendment of H.R. 850 to eliminate the proposed alterations of tax laws on the basis that such changes would:

1. Constitute discriminatory and coercive tax incentives in favor of federally endorsed health care plans and,
2. Grant unnecessary and undesirable power to the Secretary of HHS and the Congress to determine the criteria for approval of privately financed medical health care plans.

If such changes were made, H.R. 850 would then essentially be a proposal to clear the way for and encourage multiple modes of pre-paid health care delivery for Medicare, Medicaid and Title XIX patients only which, government believes, in an unfettered marketplace lead naturally to proliferation of the HMO mode and ultimate decreases in total health expenditures in the general population.

The Committee has numerous additional objections to H.R. 850 and the "pro-competition" approach, and will advance discussion of these in a subsequent paper. But elimination of the private sector from the proposed legislative concept is so crucially important that we believe this single issue should be illuminated and objected to initially and immediately.

Should the Society find merit in this approach, further attention will then be paid to the substantial problems otherwise inherent in the bill. But the Committee believes that, until this first critical alteration is made, no further discussion should be undertaken in regard to amendment of this or other "pro-competition" proposals.

THE NATIONAL ASSOCIATION OF PRIVATE PSYCHIATRIC HOSPITALS,
Washington, D.C., October 9, 1981.

ANDREW JACOBS, Jr.,
Chairman, Health Subcommittee, House Ways and Means Committee,
Washington, D.C.

DEAR MR. CHAIRMAN: The National Association of Private Psychiatric Hospitals welcomes the opportunity to submit to the committee its statement on "Competition in the Health Care System."

The National Association of Private Psychiatric Hospitals represents the nation's approximately 190 freestanding (non-governmental) psychiatric hospitals (roughly 95 percent of the private psychiatric hospitals in the country).

Our membership includes programs for children, adolescents, adults, the elderly, the alcohol and substance abuser found in all settings including mental health centers, university affiliated hospitals and programs, psychiatric units of general hospitals, which have been appropriately accredited and licensed as psychiatric hospitals, residential treatment centers for children, and short and long term hospitals. Our membership also includes all forms of ownership.

The National Association of Private Psychiatric Hospitals believes that the health care system has moved in the direction of greater competition and encourages this movement. The health care delivery system, however, is not a conventional open economic market because of the patient-payor-provider relationship. Consequently, we feel that competition in the traditional textbook sense cannot be applied to the health system.

While increased competition is needed in the health system to curtail escalating costs, any "pro-competitive" approach should be implemented with thoughtful regulation in order to assure that consumers have adequate information about competing health plans and protect unsuspecting consumers from plans that exclude important services. Competition between health plans should be based on differences in deductibles, copayments, and supplemental services. In addition, a basic package of minimum benefits should be mandated for all competing health plans.

The minimum benefit package should include all medically necessary physician and hospital services with no distinctions made between any medical specialities. Psychiatrists are included among medical specialists and psychiatric hospitals are recognized as hospitals by appropriate licensing and accrediting bodies, including the Joint Commission on the Accreditation of Hospitals. Furthermore, the World Health Organization considers all medical diagnoses equally, without differentiating between psychiatric and other medical disorders. Yet, arbitrary limits on both length of stay and/or cost of care in many public and private health programs are only placed on psychiatric disorders. This is not in the best interest of the consumer/patient as treatment must often be structured around the limitation and not on the basis of what is the most appropriate and necessary care.

NAPPH is deeply concerned that psychiatric benefits are not included in the basic benefit package of all the current pro-competition proposals:

H.R. 850 (Gephardt/Stockman) specifically excludes items and services related to mental or emotional illnesses or conditions; S. 433 (Durenberger) limits psychiatric benefits to those offered in Medicare; and S. 139 (Hatch) includes both physician and hospital services as defined in Medicare. While no specific exclusion or limitation of psychiatric benefits is mentioned, the language is ambiguous and appears open to interpretation.

The Association realizes that further refining of all pro-competition proposals will occur before any legislation is passed. The Association stands willing to assist and participate in the continuing debate on all measures designed to improve the health care financing system. We recognize that the time has come to redesign the patterns of reimbursement for psychiatric care and for all care. However, at this time we are opposed to the proposals as they stand today.

Care for psychiatric illnesses must be covered by third party payors in exactly the same way as are other medical illnesses. The psychiatrist should have the same freedom as any other physician in determining the most appropriate treatment modalities for each patient and all effective treatment modalities should be equally covered.

Care costs for the mentally ill are reviewable, predictable, controllable, and affordable. The evidence that psychiatric benefits and services offset other medical care costs is in—and is positive.

As the body and mind act in consonance, we urge this committee to recognize this fact and act accordingly.

Sincerely,

ROBERT L. THOMAS,
Executive Director.

STATEMENT OF THE NATIONAL EDUCATION ASSOCIATION

The National Education Association, representing 1.7 million professional educators, has long supported a national health plan that provides first-dollar coverage for the broadest possible range of illness and injury, a system that rewards efficiency and economy in the delivery of health services, and one which places high priority on the best cost-containment scheme of all: preventive care.

Today, in 1981, the focus of national health policy is shifting to debate on a new kind of proposal called "pro-competition" or "consumer choice." This proposal, in several variations now before Congress, has four key elements:

1. Each consumer would have to be offered a choice among competing plans for health insurance and health care delivery.
2. Government and employers who offer financial assistance would be required to offer each consumer a fixed dollar subsidy toward the purchase of coverage by any of the competitors.
3. Each of the competing health plans would be required to play by the same rules regarding the design of premiums, benefits packages, and protection in the event of a catastrophic illness.
4. Physicians and other providers would have to be organized into competing economic units, each offering a minimally comprehensive range of health care services.

NEA opposes the pro-competition bills for five reasons:

1. The pro-competition schemes appear at first blush to be concerned with replacing coercive regulation with a system of incentives, operating on both providers and consumers. But each of the pro-competition bills offered thus far would require the replacement of existing regulations with a regulatory structure nearly as complex. Regulation would be necessary to ensure a minimally acceptable level of quality in health plans that qualify for government and private reimbursement. Regulations on credentials would have to be largely retained, and those on proficiency enhanced. Otherwise, the use of unqualified personnel or substandard treatment methods could subject consumers to wholesale fraud. Similarly, regulation to guard against underutilization of services would be necessary. Consumer satisfaction might or might not be adequate or timely enough to ensure that services are appropriate.

2. The underlying theory of the pro-competition model is fallacious: individual consumers, if given a choice, will make knowledgeable and economically rational choices that will result in better insurance and provider behavior. Two examples illustrate the fallacy of this theory.

(a) By the time a consumer seeks medical assistance, consideration of cost is secondary to the quality of service offered. If one shops around at all for medical services, the choice will tend to be made on a judgment of what would be most effective. "Give Mom the best—she deserves it," is a controlling mindset for the medical consumer.

(b) If consumers want to know the price of doctors or hospitals, they do not have adequate information for a competitive survey. Ask any hospital how much an appendectomy costs, and the answer will be that the cost may vary depending on time in the operating room, whether complications develop, whether around-the-clock nursing is required, and so on. Doctors rarely quote prices over the telephone, and are known to hedge even when confronted personally.

A further difficulty with the theory lies in the fact that the doctor, not the consumer, makes the choice of treatment. In most situations, admission to a hospital requires referral by a doctor. And patients don't write prescriptions; doctors write them. Even if a patient can make a cost-effective choice of doctor, he or she may not have any control over the cost of drug therapy or hospitalization prescribed.

3. The pro-competition proposals use the tax system to limit employer contributions to employee health insurance plans. Some variations of the proposal would

limit the extent to which the employer's health benefit premium payment is tax exempt for the employee. The theory of this notion is that given a chance, the employee would seek to minimize his tax by accepting the health care plan that does not exceed the tax exempt amount. In actual fact, the young and healthy employee would most likely choose a low-option plan and the aged or sick employee would select a high-option plan regardless of cost. As a result of how insurance companies set premium rates, the high-option premiums would soon go through the roof. The low-option coverage is risky, the high-option coverage would soon be beyond reach. Bills which provide a rebate to employees who choose plans with premiums lower than the employer's standard contribution would accelerate this adverse selection process.

4. The pro-competition plan could wreak havoc with the orderly collective bargaining process, setting basic health care above and beyond the scope of negotiation. Health care coverage is a prime issue in virtually all public and private negotiations. Through negotiated coverage, whether fully or partially paid by the employer, American workers and their families today enjoy standards of health care undreamed of a quarter of a century ago. It is doubtful that a worker would want to forego such coverage in the interest of holding costs down . . . even if the pro-competition plan could realistically offer to do so.

5. The principal shortcoming of the pro-competition approach is that it does nothing to ensure access to quality health care. It affects only those who are employed, and then not benignly. It addresses no question of interest to the unemployed, the underemployed, or the aged (although one scheme touts vouchers as an alternative to Medicare). It could raise new revenues by taxing premiums paid over and above the set standard, but this is hardly a health benefit. And it really does nothing to contain medical care costs; it simply puts a damper on coverage.

Therefore, NEA urges the Committee to develop a national health policy that would provide financial protection to consumers, better access to health care for all Americans, and measures to curb runaway health care inflation. The name for such a plan would have to be "national health insurance," and the vehicle could be found in the archives of the 96th Congress under the following bill numbers: HR 22 and S 3, sponsored by Rep. James C. Corman and Sen. Edward M. Kennedy, respectively.

STATEMENT OF THE NATIONAL MENTAL HEALTH ASSOCIATION

This statement is submitted by the National Mental Health Association, a voluntary organization organized at the local, state, and national levels. NMHA has approximately one million members and volunteers who are concerned about research, prevention, and treatment of mental illness. Our membership includes consumers of mental health services, family members of consumers, and concerned citizens with an interest in this field.

This statement addresses the impact of the various "competition" bills introduced in the 97th Congress upon the mentally ill consumer and his family. NMHA has not taken a specific position concerning the concept of encouraging greater competition along the lines suggested by these bills; nor has NMHA taken a specific position over the issue of whether a voucher system for Medicare and/or Medicaid recipients is advisable.

This statement therefore addresses primarily the issue of inclusion of the services required by the mentally ill under insurance policies; and much of that discussion would apply as well to Medicare reform issues or coverage under any insurance policy as it does to the competition bills. The statement also raises a few fundamental questions concerning the operation of the competition principle, as it pertains to the mentally ill and to the handicapped.

The competition approach

NMHA has long been concerned about the soaring costs of health care in the United States. Additionally, we have continually supported legislative proposals designed to assure access for all, at a price all can afford, to an acceptable level of high-quality medical care within a system which builds incentives for cost containment. We have some questions concerning procompetition proposals now before the Congress which seek to achieve greater cost-consciousness and individual responsibility in the selection of insurance coverage and attempt to combat the overutilization of health care caused by subsidized health insurance.

In our view, any proposal to reform the current health care system must deal simultaneously with assurances of equitable access to health care, quality of health care, and cost of health care. It is clear that we must be careful that we do not attempt to solve our health care cost problems by rationing people out of the health care system.

First, it is important to recognize that health care is a unique market commodity. Medical care is different from other kinds of goods and services bought and sold in the market system. For many people, the selection of health care is a highly personal, emotional, and important decision. Especially consumers faced with a serious illness are not going to shop in the market as they would normally do for other commodities. The current competition proposals, by assuming that health care consumers have adequate actuarial, economic, and medical knowledge to make rational decisions about health insurance plans, place the consumer at risk. Expecially in the case of the mentally ill and disabled, as well as the elderly and the poor, the assumption that necessary information is available and that rational decisions regarding needed health care coverage will result is highly speculative and risky. Although the concept of increased consumer freedom of choice regarding health care is attractive, any competition proposal should insure that all consumers will have access to accurate, easily understand explanations of the various health care options available.

The health care market is also unique in that consumers do not in effect control the demands for health care. Current proposals imply that consumers are free to shop around regardless of their doctor's wishes or opinions. In fact, the only choice the health care consumer usually has regarding medical care services is the initial selection of a doctor. Therefore, competition proposals must aim at lowering premiums based on the insurer's ability to motivate providers to compete in price, rather than concentrating on incentives which may induce consumers to underinsure.

Current competition proposals may become a vehicle by which the elderly, the disabled, and the poor disinsure themseleves. The proposals would levy a punitive tax on all those selecting a comprehensive health coverage plan. We are concerned that the availability of a tax-free rebate for selecting a low-cost premium will result in low-income people gambling the health of themselves and their families against the opportunity to receive "cash in the pocket." Especially with regard to the Medicare and Medicaid voucher proposals, we fear the unintended consequence that such a system will place the beneficiaries at risk through the selection of a low-coverage premium to save money. Such low-premium plans will undoubtedly have high deductibles and high coinsurance requirements and very minimal, if any, mental health coverage.

We are also concerned with the long-term effects of a Medicare and Medicaid voucher system as it may result in the continual decrease of coverage for beneficiaries. If such a voucher system is adopted, it is predictable that the average value of the vouchers will not increase with the rate of inflation. The competition may instill a mechanism whereby public assistance for health care for the elderly and the needy is reduced to inadequate level through underfunding of the voucher system. Also, it must be recognized that private insurance companies have much higher administrative costs than is presently the case in the administration of Medicare. This makes it virtually impossible for private insurance companies to provide identical benefits as Medicare at less cost. The voucher system will not be able to reduce costs unless it reduces services. Additionally, private insurers would be forced, under the voucher proposal, to "skim the cream of the crop" and only enroll low-risk beneficiaries, thereby leaving the most needy to the government.

The competition proposals thus might induce adverse selection where the young and healthy would choose a low-cost plan driving the cost of comprehensive coverage for the elderly, sick, and disabled to the point where it is not longer affordable. As a result of adverse selection, health insurance for the chronically ill and the mentally ill might become unavailable at any price and minimally adequate benefits may be eliminated as a result of increased cost awareness by insurers. When health insurance benefits are reduced as a result of adverse selection, benefits for costly hospital and physician services are often retained at the expense of coverage for other less costly services, such as mental health services, dental care, and prescription drugs.

Congress must analyze carefully these competition proposals as a means of reform for the health care industry. It is crucial that Congress include in these competition proposals a mandate for an adequate array of services in the minimum benefit plan. As a cost containment strategy, any competition proposal should operate to move treatment to the least expensive setting. The health care industry needs to break away from reliance on expensive institutional care. Current proposals must be amended to include ambulatory, preventive, and maintenance health care so as to avoid the costly acute and chronic health care the industry now services.

MENTAL ILLNESS: THE EXTENT AND IMPACT OF THE PROBLEM

Mental illness is not confined to a small minority of the population—it is a major category of illness which costs Americans billions of dollars per year. About 32 million people need some form of mental health services in a year: 2.1 million of them are schizophrenic; two million suffer from profound depression; one million suffer from organic psychosis of toxic or neurological origin or permanently disabling mental conditions. Many of the 40 million physically handicapped Americans have emotional problems related to their disabilities, and fully 25 percent of those over 65 (or 5.8 million) have significant mental health problems. More people are admitted to hospitals because of mental disorders than for any other illness.

Billions of dollars (in excess of $30 billion) are lost each year through lost productivity due to mental disorders.

COVERAGE OF MENTAL HEALTH SERVICES UNDER INSURANCE

Currently, health insurance policies in the United States provide grossly inadequate coverage for mental illness. Moreover, the coverage which is available generally operates so as to discourage early treatment, and to emphasize inpatient services, instead of the frequently more suitable outpatient service or partial hospitalization (i.e., day treatment or overnight care).

Thus, for various reasons, the marketplace has not yet permitted the mentally ill to share in the principle of insurance: that the risk of illness and cost of treating such illness should be spread over the insured population. Instead, the mentally ill are required to pay a far greater proportion of their own treatment costs, and often must accept less appropriate treatment because that is the only treatment covered by their policies. Ironically, this situation increases the total costs of providing services to the mentally ill under the public and private systems.

H.R. 850 would make this situation even worse, by specifically excluding from the required benefits any service for mental or emotional disorders. Objections to including mental health coverge under insurance policies are usually based on the following arguments: Mental health utilization cannot be controlled; mental health services are too costly; if consumers wish for such coverage, they will demand it; and the wide range of "nontraditional" providers who furnish mental health treatment leads to concerns about quality, fraud, and abuse.

(a) Mental health services: Utilization and cost.—Data on utilization and costs of mental health coverage strongly support the premise that short-term therapy for acute mental illness is very insurable. Moreover, there are numerous studies which indicate that cost savings can accrue to the total costs of health care when an appropriate mental health benefit is available (offset studies). Also, a well-designed mental health benefit, which appropriately covers and encourages ambulatory care (i.e., outpatient or partial hospitalization), and which encourges early intervention, is, in the long term, less costly than the current practice of most insurance companies to emphasize inpatient hospital care.

A study by Korff and Kramer, "Mental and Nervous Disorders: Utilization and Cost Data for Outpatient Services," analyzed over 12 different insurance plans. Data showed that the percentage of insured individuals using mental health benefits during one year ranged from 0.6 to 2.2 percent. Of those who used services, the average number of visits in a year ranged from 4.2 to 9.3 (excluding one plan, the Health Insurance Plan of New York, which averaged 18.8 visits). The study also reviewed data from the Federal Employees Health Benefit Program, which offers unlimited outpatient mental health coverage, and found two percent of the insured population were using mental health coverage, with an average number of visits in the range of 32.71. Charges averaged $1,300 per person using services, or $26.51 per insured individual.

These data indicate: That only a small proportion of an insured population use outpatient mental health care, and the number of visits per treated person is usually small, when utilization is controlled by some combination of copayments, deductibles, and visit limits.

Another body of data now exists which indicates an interesting phenomenon: that mentally ill individuals utilize covered services under their insurance plan, even if mental health services are not available to them. These individuals then show up in insurance data as seeking other medical treatment. When an appropriate mental health benefit is made available, reductions of misutilization of other medical services results in substantial cost savings. Some of these studies are summarized below:

Blue Cross of Western Pennsylvania assessed the medical/therapy outpatient benefit in community mental health centers with a comparison group of subscribers for whom such services were not made available. The findings showed that the medical/surgical utilization rate was reduced significantly for the group which used the psychiatric benefits. The monthly cost per patient for medical services was more than halved—dropping from $16.47 to $7.06. The overall cost to the insurer (with mental health treatment factored in) was reduced by 31 percent.

A study by Rosen and Wiens at the Medical Psychology Outpatient Clinic at the University of Oregon Health Science Center studied both children and adults (using a control group) and found significant group effects for changes in the number of medical outpatient visits, pharmaceutical prescriptions, and diagnostic services. For each of these three measures, those receiving mental health services reduced their use of medical outpatient services by 41 percent. Data indicated that this change was taking place with all patients, not just high utilizers of medical services.

Group Health Association of Washington indicated that patients treated by mental health providers reduced their nonpsychiatric physician usage within the HMO by 30.7 percent in the year after referral for mental health care compared to the previous year. Use of laboratory and X-ray services declined by 29.8 percent.

Kaiser Plan in California estimated that the subsequent savings for each patient receiving psychiatric treatment were on the order of $250 per year.

A study to explore the impact on general outpatient medical care utilization resulting from outpatient mental health intervention was conducted by Group Health Cooperative of Puget Sound. This study used two study groups: one with prepaid members, and one consisting of fee-for-service patients. The study groups began with high-utilization rates, as compared to the controls, and after receiving treatment, declines in their utilization rates were found to be very substantial. Medical care utilization for these study groups dropped to a level comparable to the controls. The study found little difference in the overall utilization patterns of prepaid and fee-for-service groups.

In summary: Insurance companies are now paying for mental illness under existing physical illness benefits without being aware of it.

Total costs to the insurance system may be reduced when patients are able to obtain appropriate mental health treatment in both inpatient and outpatient settings.

The actual cost of outpatient mental health benefit per individual covered by the policy is modest.

(b) Consumer choice.—The argument that if consumers want mental health coverage, they will purchase it, ignores several realities:

In group policies, those anticipating that they might utilize a mental health benefit are frequently reluctant to ask their employer for such coverage because of the stigma against mental illness and fear of reprisals.

Stigma against mental illness also leads many people to anticipate that they will never need such services.

(c) Providers of care.—Many of the "less traditional" providers of mental health care, such as community mental health centers, emphasize ambulatory treatment and early intervention. Thus, they can reduce inappropriate institutional care, thereby reducing costs. Day treatment programs, also a relatively new "nontraditional" form of treatment, have already been demonstrated more effective and less costly for many patients who might previously have been admitted for institutional care.

There are also, for mental health providers, as for other providers of health care, many systems in place to address issues of quality and accountability. Standards have been established for CMHCs and other agency providers; states license individual practitioners, and insurance policies can further specifically define which of these services can be utilized under the policy. Thus, the issue of defining who provides the service can be dealt with in a very rational way.

(d) Impact of excluding the mentally ill under competition legislation.—Any legislation which defines a minimum benefit package for insurance policies must include a minimum acceptable benefit package for mental illness, one which emphasizes ambulatory care. Requiring such policies to include coverage for other health services, but not specifically requiring them to cover mental health services, would exacerbate the current problems with mental health coverage under insurance policies, and undo much of the work of consumer groups and other advocates for the mentally ill to educate and encourage insurance companies to provide such coverage. The exclusion under HR 850 is unquestionably discriminatory, and will single out for adverse treatment under the legislation a very vulnerable group of sick individuals. Moreover, the impact of this exclusion will be clearly felt in other parts of the public budget. Provision of services for the mentally ill is now a clear responsibility of state and federal governments, in large measure because there is no alternative for the chronically mentally ill and others who suffer from mental illness but who cannot afford the total cost of their necessary care. HR 850 simply shifts even more of a burden on the public outpatient and state institution system, and relieves the private insurance industry of the necessity of spreading the risk of mental health treatment costs among the working population and others who might be covered by such policies.

The problem of consumers choosing to underinsure suggests that including in any competition bill a minimum set of benefits for all policies is a good idea, provided that such minimum benefits include mental health services. However, in devising such benefits, NMHA urges the subcommittee not to merely pick up the current Medicare coverage. Medicare currently provides extremely minimum outpatient coverage (and no coverage of partial hospitalization), as well as limiting lifetime benefits for psychiatric hospital services. As a result of the inappropriate coverage, 80 percent of mental health costs under Medicare are for inpatient services. It is therefore extremely important not to build any new system upon the mistakes of the past.

In conclusion, NMHA also supports the statement submitted by the American Coalition of Citizens with Disabilities. Their concerns about the impact of this bill upon the disabled population (both the physically and mentally disabled) are shared by NMHA.

STATEMENT OF STANLEY BREZENOFF, PRESIDENT, HEALTH AND HOSPITALS CORPORATION OF NEW YORK CITY

As President of the Health and Hospitals Corporation (HHC) of New York City, I welcome this opportunity to comment on legislation which, if enacted, would strive to reform health care delivery systems while assisting all Americans in obtaining health care. Because HHC is primarily responsible for services to New York's least affluent population, we are particularly receptive to innovative national thrusts which could slow increases in the cost of providing health care without compromising the quality or the necessary quantity of that care.

We are wary, however, of any such proposals which rely on public sector health programs—Medicaid and Medicare in particular—as a mechanism for controlling health care costs. Enormous numbers of the nation's poor and elderly need these programs to survive, and any plan to diminish medical coverage for them would be socially unconscionable.

In addition, public hospitals—such as the sixteen hospitals and numerous satellite clinics and auxiliary care services under the umbrella of the Health and Hospitals Corporation in New York City—could not continue operations at an acceptable level without an adequate level of Medicaid and Medicare reimbursement which continue to be increased to compensate for economic inflators. HHC currently relies on Medicaid and Medicare for 85 percent of all third-party reimbursements.

Consequently, among all the health-related cost containment proposals now before Congress, the one which portends serious disruption in health care financing for public hospitals which service a disproportionate number of the poor and the elderly, is a plan to offer fixed price vouchers to the Medicare-eligible population.

Legislation now under consideration if enacted, would permit all Medicare eligible individuals to use vouchers to purchase medical insurance from a qualified private insurer. Given a voucher of a specified dollar amount, Medicare eligible consumers could select a plan with a cost in excess of the amount shown on the voucher and pay the difference to the insurer or, alternatively, select a plan below the voucher allotment and retain the difference as a tax free cash bonus.

Consideration of proposals to create a voucher system in place of the current Medicare system comes at a time when control of the federal budget is a national preoccupation. In this context it is no surprise that both the Administration and Congress would wish to stabilize rapidly increasing costs of all public sector health programs. There is no guarantee, however, that an immediate reduction in federal expenditures on health care in general—or on Medicare in particular—would automatically reduce the enormous expense involved in providing quality health care. At the same time, both the Medicare participant and the health care provider would certainly face disaster if the dollar value of a Medicare voucher were kept artifically low for the sake of budget savings, no matter how substantial.

An abrupt reduction in federal expenditures on Medicare simply means that the funds have to come from another source. For public hospitals, access to other funding souces really means appealing to local and state governments for support from overly strained tax revenues. Currently, the City of New York contributes approximately $341 million in tax revenues to HHC. Aside from Medicaid and Medicare, third-party reimbursements are almost nonexistent in public hospitals. We cannot use private insurance to offset our deficits nor can we expect the medically indigent or the working poor to defray our expenses. Therefore, failure at the federal level to provide adequate funding to cover the expenses of Medicare recipients will result in a major shift in the cost and the responsibility for health care to municipal budgets.

Unless a Medicare voucher reflects reasonable costs for care, public hospitals could not afford to sustain even the most basic health care services. Failure to reflect in Medicare vouchers the actual increase in the cost of providing health care—on a timely basis—will also undermine services rather than bringing down the costs. In short, a Medicare voucher plan which at the outset doubles as a cost containment measure will not only result in an unacceptable strain on non-federal budgets, but will surely cause an erosion in health services as well.

Proposals to create Medicare vouchers are also predicated on the belief that the Medicare-eligible population will be good consumers of health care insurance. It is more likely that this population is unprepared for the difficulties involved in selecting insurance. For many, medical insurance was provided during employment. Choices were kept to a minimum and the solvency and scrupulousness of the insurance companies were guaranteed by the employer. A person who has turned 65 and is facing recurring and probably more serious health problems is hardly in a good position to encounter for the first time the complexities of shopping for health insurance.

There is even more reason to fear that patients who rely on public health facilities will have trouble coping with the purchase of private health insurance. It is a sad fact that many of our patients are badly in need of funds just to cover daily expenses. The opportunity to buy low cost health insurance and keep the cash difference from the voucher must be very attractive to many of these patients. Low cost health insurance, however, does not guarantee anything but the most minimal coverage. Given the likelihood for serious illnesses and multiple diagnoses in advanced years, minimum coverage would be inadequate in most cases. Meanwhile, public hospitals cannot and will not permit the level of insurance benefits to determine the extent of care they provide; the Health and Hospitals Corporation has a mandate to provide whatever care is necessary regardless of a patient's ability to pay. Therefore, if a patient has minimal coverage and scarce resources, it is the public hospital which, again, absorbs the cost for unreimbursable care. Yet, it is the public hospitals which lack the financial wherewithal to cover bad debts.

In addition, conditions for individuals to select the voucher plan may have the consequence of prohibiting reinstatement in a non-voucher Medicare plan. Patients who need maximum coverage but cannot afford expensive premiums charged by private insurers may need to return to Medicare in its current direct reimbursement format. Will this be permitted? If not, the federal government may be inadvertently transforming those in need of costly chronic care into a whole new population of the medically indigent. On the other hand, if patients are allowed to opt out of the voucher plan when more extensive medical care is required, Medicare in its present form may end up as a last resort for chronic care patients, entailing expenses exactly comparable to those borne by the federal government under the present system. Thus, no savings result from the change.

Currently, a significant percentage of the population served by the Health and Hospitals Corporation in New York City turn to Medicaid when their Medicare benefits are exhausted. Presumably, for those who select the voucher plan, the Medicaid program will no longer serve as the reserve fund for the elderly poor. With the potential for fewer benefits and greater restrictions on reimbursement to providers by private insurers, the number of unpaid medical bills in public hospitals could be staggering.

In a manner never before required, private insurance companies will be forced to deal with the nation's poor. It is a less than ideal prospect for all concerned. A new and different federal bureaucracy will have to be created to regulate the practices of private insurance companies. While the thrust will be different, it is hard to imagine that the government will be any more successful in extricating itself from the detailed regulation of the health care industry if it is to continue to maintain its responsibility for the disabled, the aged and dependent children as mandated by the Social Security Act.

Upon enactment of a Medicare voucher plan, the federal government would have to certify, on behalf of the Medicare-eligible population, the integrity, the solvency and the accessibility of private insurers. Federal administrators would also have to guarantee a satisfactory balance between the needs of insurance companies both to secure profits and to market programs with the special needs of the Medicare-eligible population. Private insurers will have to be prevented from using costly premiums as a means of transferring what is currently regarded as fundamental health care services such as preventive care, adequate long term care and home health services into a new category of luxury services available only to the wealthy. Health insurance cannot be held in reserve just for catastrophic illnesses nor can it be geared exclusively to a group which is younger and healthier than the Medicare population.

Transferring reimbursement for health care for the Medicare-eligible population would also force the federal government to develop alternative subsidies for the purchase of hospital equipment, inducements for research and experimentation and compensation for expenses unique to teaching hospitals. Currently, these costs are absorbed in part by adjustments in Medicare reimbursement rates.

We appreciate this opportunity to comment on legislation now pending before this subcommittee. While we have expressed considerable reservations about proposals to create a voucher system for Medicare-eligible individuals, we very much support the efforts of the subcommittee to search for an effective and fair means of containing the costs of health care.

STATEMENT OF DAVID A. PYNER, M.D., PRESIDENT, OMNIDENTIX SYSTEMS CORP., WESTWOOD, MASS.

SUMMARY

Dr. David A. Pyner, an internationally known dentist, author and lecturer, along with David B. Slater, formerly the President of the 1,000 unit Mr. Donut restaurant chain, have developed a business system which enables dentists to lower their fees by 20 percent to 40 percent to the public.

This system proves that costs can be reduced in dental care and the savings passed on to the patient. However, the Massachusetts Dental Licensing Board has tried everything in their power to stop the spread of this innovative, cost effective, cost effective, quality approach to dental care.

STATEMENT

I am submitting this written testimony for inclusion into the record on behalf of House Bill 850.

By way of introduction, I have been a practicing dentist for 17 years. In addition, I have been on the teaching staff of Boston University and have written a dental textbook which is currently being published in five languages.

Dentistry today accounts for a significant portion of the health care dollar. By 1985, 34 billion dollars will be spent yearly on dental care and 60 billion by 1990.

One of the main factors which increases costs is that dentistry is a fragrmented cottage industry which cannot by its very nature be cost effective. In addition, state dental board regulations dictate restriction on professional advertising, expanded use of dental auxiliaries, and ownership of dental practices. All this discourages innovative efforts in dental care.

In order to reduce costs, more business techniques must be applied to the delivery of dental care. Therefore, I strongly support House Bill 850, and especially Section 302 of this bill. This section will enable business corporations to play a more direct role in the business aspects of delivering dental care.

Unlike dentistry, business corporations now help physicians deliver medical care in such varied settings as Kidney Dialysis Centers, Psychiatric Hospitals and outpatient Surgical Centers. Are Dental Boards trying to tell the American people that their molars are more important than their kidneys? Or is it that the Boards are restraining competition to artificially protect the status quo, and as a by-product maintan high dental fees. Is it right that a crown for one tooth costs $450? Your dentist tells you that this high cost is due to the increase in the price of gold, but many dentists no longer even use gold in crowns.

With all this in mind, I set out to develop a cost effective prototype of the way dentistry should be practiced in the future. Thus, David B. Slater, formerly the president of the 1,000 unit Mister Donut restaurant chain and I formed Omnidentix Systems Corporation. Omnidentix is a business which sets up, on a turn key licensed basis, dentists to practice in large groups in enclosed shopping malls and other high traffic retail locations for a maximum consumer visability and accessability. The practice maintains for consumer convenience, long retail hours and is opened from 8 a.m. to 9:30 p.m. every day including Saturdays. Like other retailers, the practices promote their services under a trade name Omnidentix, by using modern merchandising techniques and advertising. Financially, the practices use typical retail business controls to keep inventories, staffing levels and other nonfixed overhead in line. Because volume is high and overhead is spread over a large patient base, the fees to the consumer range form 20 percent to 40 percent below current usual and customary fees in the community, depending on the services rendered, while maintaining the highest quality standards. For example, that $450 crown is only $269 at the Omnidentix Dental Center and a full 2-year orthodontic treatment is only $1199.00.

The prototype dental center opened in August, 1980 in the Meadow Glen Mall in Medford, Massachusetts. In the first week of operation over 1,000 appointments were made. We were astounded to say the least.

The media, always looking for a good consumer interest story, quickly became interested in Omnidentix. Without solicitation, the Boston Globe, Venture Magazine, the Associated Press, among others wrote articles on Omnidentix. ABC-TV News sent a crew to Boston from New York and featured a story on Omnidentix which ran nationally on the network evening news, and even ran also as a segment on their Good Morning America telecast. Warner Cable TV dd an entire consumer program on Omnidentix.

Our second licensed dental center opened 3 months ago in the North Dartmouth Mall in North Dartmouth, Massachusetts, and it too has stimulated a terrific patient response. A third center is under construction and will open in the Cape Cod Mall in Hyannis, Mass. in 4 weeks and lease for a fourth dental center has just been signed in Boston.

The Omnidentix concept has become extremely successful . . . too successful, judging from the fact that the Massachusetts Dental Licensing Board has tried everything in their power to stop the spread of this innovative, cost effective, quality approach to dental care. First the Board tried to suddenly alter their advertising regulations, making them inordinately restrictive. These same advertising regulations had only been recently liberalized by the Board to permit dentists to advertise in concurrence with the U.S Supreme Court decision in Bates vs. Arizona and the Federal Trade Commission's consent decree with the American Dental Association. The agreement provided essentially that dentists could advertise as long as the advertising wasn't false or misleading.

But that consumer triumph by the FTC helps demonstrate the inate restrictive attitude of the dental boards and industry associations.

The Dental Board held a hearing on advertising. WBZ-TV, Boston's NBC affiliate, condensed the hearing into an approximate 15 minute segment which was broadcast on their highly rated consumer program, "Moneysense". At the onset of the hearing, the Chairman of the Dental Board stated that the Dental Board's only interest in altering their current advertising regulations was the protection of the consumer. At the end of the hearings, the WBZ reporter asked the Chairman of the Dental Board, on camera, with all this clamoring to change the dental advertising regulation whether the board had received many complaints from consumers relating to dental advertising. The Chairman went blank for a moment, and then very hesitantly said, to the best of his recollection, no consumer complaints had been received on the subject of advertising. The reporter then confirmed that the Board had not received any consumer complaints on advertising in the last 3 months but had received complaints from dentists concerning the regulations which let other dentists advertise.

In addition to trying to change the advertising regulations, the Board at the same time issued to me an order to show cause, to revoke my license to practice dentistry. The charges were a laundry list of complaints, not one of which dealt with patient care.

They dealt with using photos of our staff dentists in my advertisements, advertising that our prices were lower, and that by saying the Dr. David Pyner was a member of the Omnidentix Business Systems, I was somehow defrauding or misleading the public.

In the opinion of the State Attorney General assigned to the Dental Board I was doing nothing illegal and after a very expensive 9 month fight, the Board was forced to dismiss my show cause order. That did not end the problem. The Dental Board then turned around and cited our individual dental center licensees for violation of the Dental Practice Act which essentially were the same violations they had just dismissed in my order to show cause.

The actions of the Massachusetts Dental Board are not untypical of State Boards around the country.

If Congress is truly interested in lowering the cost of health care, Congress must be prepared to deal with these State Board regulations in a meaningful way. It may be that the Dental Board's interest was not in just protecting the consumer, but also in preventing economic competition within the profession which might affect the well established dentist. This is the same economic competition that both President Reagan and the Federal Trade Commission want to promote in Health Care. It is now up the members of this Committee. Omnidentix has proven competition will definitely lower fees to the consumer, make dentistry more accessible to more people, and increase the patient base.

STATEMENT OF O. RAY HURST, C.A.E., PRESIDENT, TEXAS HOSPITAL ASSOCIATION

We appreciate the opportunity to submit some preliminary views for the hearing record on the subject of pro-competition/consumer choice health plans, as proposed by legislation, and under study by the Administration and a task force of the Department of Health and Human Services. We commend the members of the subcommittee for their interest and support of such hearings to provide a forum for ideas on very complex proposals which would essentially result in restructuring the delivery and payment provisions for many health services programs.

This subject has been frequently reviewed by various authors, economists, academicians, professors, government officials and congressmen since the initial introduction of representatives Gephardt-Stockman's National Healthcare Reform Act of 1980—to deregulate the health care industry and permit competition to contain health care costs.

As you are aware, proposals to reform our health care delivery system, other than H.R. 850 by Gephardt and Stockman, are to be finalized and presented by the Administration and interested congressmen. Previous congressional budget reductions and the most recent additional budgetary reductions proposed by President Reagan on September 24 for Fiscal Years 1982-84 will impact any final reforms in our health care delivery system.

Our Association which presently represents over 800 institutional and over 4200 personal members has been actively interested in and involved in Medicare and Medicaid since their organization and the periodic reforms in such programs throughout the decade of the 1970's. We have been deeply interested and involved with the organization, implementation, and periodic reforms of the amendments to the Social Security Act of 1972 (P. L.-603), the National Health Planning and Resources Development Act (P. L. 93-641) and the myriad of guidelines and regulations thereof, the development and operation of Health Systems Agencies (HSAs) and related state agencies, the development and operation of professional standards review organizations, the elimination of over regulation at the state and federal level, as well as active participation in recent national and state voluntary cost control efforts.

Since the original introduction of Representatives Gephardt and Stockman's National Health Care Reform Act of 1980, we have initiated educational forums on pro-competition/consumer choice health plans and the most recent reforms in federal health programs through the Omnibus Budget Reconciliation Act of 1981 and the Economic Recovery Tax Act of 1981.

To us, pro-competition or consumer choice reforms are labels for a recognized needed change in the traditional allowable cost system of payment by government for hospital and medical services.

There seems to be little reason to complicate the issues—the complication comes in methodologies proposed to date regarding implementation. It is time to look to simplicity in system design—a return to the aged population of an amount commensurate with the amount paid in by that population.

Based upon such involvements, we submit the following general comments for the hearing record.

By unanimous vote, the Board of Trustees of the Texas Hospital Association by resolution March 20, 1980, endorsed, in principle, President Reagan's economic program and urged immediate congressional approval of subject program.

Our Association fully supported and endorsed President Reagan's August 1981 directive to establish the Presidential Task Force on Regulatory Relief headed by Vice President Bush, and current efforts to review onerous health planning and other health related regulations.

Our Association has strongly opposed previous Administration programs to place arbitrary "caps" on federal expenditures without considering necessary alternatives.

We have also strongly opposed the myriad of recent federal regulatory controls over the delivery of health services and the financing thereof.

As to earlier proposals in regard to catastrophic health insurance, our Association supports the following principles as they may apply to catastrophic health insurance:

Catastrophic health insurance should be provided to all Americans.

The extension of catastrophic health coverage should rely on the private sector as much as possible.

A federal program should only serve as a back-up to private programs enabling any who cannot afford other insurance to be covered.

A plan which builds on private health insurance coverage among the employed population, provides tax incentives to purchase such coverage and provides special assistance to small employers, state and local governments and non-profit organizations, is desirable.

The method of financing should include private premium payments, general tax revenues, and payroll taxes to allow for maximum flexibility and innovation.

A centralized administrative and fiscal control structure for the health care system would be detrimental to the quality of health care and result in a costly, top-heavy bureaucratic system.

Our Association supports, in principle, the resolution adopted by the American Hospital Association House of Delegates February 1981 regarding consumer choice health plans. The resolution in essence endorsed the following principles of consumer choice approaches to financing health care: mandatory choice of plan, fixed contribution regardless of choice and a limitation on the tax free status of contributions.

We also support Secretary Richard S. Schweiker's earlier caution to Congress about jumping "pell mell" into a broad scale program and further support his recommendation to institute model projects with related tax revisions to encourage business and individuals to test the benefits of a consumer choice health plan prior to any nationwide implementation.

Based on various consumer choice proposals, a hospital's connection with various prepaid health service plans (health maintenance organizations, etc.) may well mean that hospitals would face many new fundamental decisions on corporate structures, financial risks, and payments.

Our Association fully supports the position that any pro-competition or consumer choice health service plan must gain widespread acceptance of the provider community and more particularly the approval and participation of physician providers. Without widespread acceptance and support of physicians, few, if any, consumer choice health service plans, as may be originated by the federal government, will be effective or survive in any local or regional area.

Given the recent health care reforms, we respectifully urge subcommittee members to be mindful of the present and future shift of responsibility between the federal and state governments in the administration, operation and funding of the Medicaid program effective October 1, and particularly so in regards to present or future studies regarding a voucher system as proposed by H.R. 850 for Medicare and Medicaid recipients. We strongly suggest that states will require from one to four years to fully recognize the shift of responsibility and the resulting implications upon state budgets and manpower resources for the Medicaid Health Program. We urge the subcommittee, full committee and Congress to delay or if necessary, establish a moratorium on any study or the implementation of any federal voucher type program for medicaid recipients before fiscal year 1984—at the earliest. States must be given a chance to stabilize, organize and operate their Medicaid programs without additional federal legislative or regulatory restraints.

Any federal consumer choice health program must appropriately consider the "demand side" for such services as well as the federal government's ability to appropriately fund such services. Any pro-competition or consumer choice health plan should consider the impact of such plans on the operation of all types of hospitals (rural hospitals; teaching hospitals; large, urban type facilities).

The provisions of Section 302, H.R. 850 may provide an essential cornerstone for the effective operation of any government supported consumer choice health plan in order to minimize rivalries between various health professions in the delivery of care under such plans. A proper role of federal legislation is to assure uniform opportunities for all eligible recipients of care from all providers in all states. Any action taken to bring back the proper involvement of the private sector cannot be aborted or improperly moderated by state law. In a free marketplace arena, opportunities to assume financial risk and rewards must be equal for all health providers.

Uniquely, Texas has an insured program with a private sector contractor, at risk, for purchased health services under Title 19, Medical Assistance Program for Texas. Our Association stands in solid support of such an insured arrangement for payment of medicaid services, with claims processing, provider relations, and the appropriate assumption of risk remaining responsibilities of the private sector.

The sound tenets of the free enterprise system are inherent in an insured arrangement for payment of medicaid services to our Texas citizens. There is a bidding process, a predictability of cost through payment of premium, and the incentives of efficiency and cost control resulting from the contractual assumption of risk and requirement of performance by the private sector.

The scope and objectives of the next major health reform legislation may, by national policy, become a cornerstone or central pillar for some type of future universal, comprehensive, or national health insurance program. Any major health reform, be it pro-competition, consumer choice or otherwise, with the potential of maintaining the quality of this nation's health care at a cost we can afford, warrants the very best and thorough study that the private and public sectors can undertake. Our Association is studying the concept and application of marketplace incentives in the health delivery system and we look forward to participation in the future refinement of these approaches.

Again, thank you for the opportunity to present this information for printing in the record of the Subcommittee hearing on this subject.

INTERNATIONAL UNION, UNITED AUTOMOBILE, AEROSPACE
& AGRICULTURAL IMPLEMENT WORKERS OF AMERICA—UAW,
Washington, D.C., October 5, 1981.

Hon. DAN ROSTENKOWSKI,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, D.C.

DEAR MR. CHAIRMAN: Melvin Glasser, Director of the Committee for National Health Insurance (CNHI), appeared before the Subcommittee on Health last week to testify on behalf of Douglas Fraser, the Chairman of CNHI. The prepared testimony was addressed to proposals which purport to stimulate competition in the financing and delivery of health care. Specifically, the testimony referred to such measures as H.R. 850, S. 139 and S. 433, all of which we oppose together with CNHI and other organizations with membership in the Committee.

The purpose of this letter is to make it clear that the UAW fully endorses the testimony presented last week by Dr. Glasser. We urge strongly that you give the views expressed in that testimony favorable consideration.

For your information and your reference, I am enclosing a copy of Dr. Glasser's testimony [omitted].

Sincerely,

DICK WARDEN,
Legislative Director.

STATEMENT OF WILLIAM P. THOMPSON, STATED CLERK, ON BEHALF OF THE GENERAL ASSEMBLY OF THE UNITED PRESBYTERIAN CHURCH IN THE UNITED STATES OF AMERICA

My name is William P. Thompson. I am Stated Clerk of the General Assembly of the United Presbyterian Church in the United States of America. The General Assembly is the highest governing body of the denomination, a judicatory of approximately 750 commissioners, half laypersons and half clergy, elected by 162 Presbyteries in fifty states, within whose bounds are 2,916,757 members. I recognize that within the total membership of the church there are individuals holding differing and sometimes conflicting views. I do not presume therefore to speak on behalf of each and every member of the church. In presenting this testimony to the Subcommittee, I speak on the basis of the policies adopted by the General Assembly of the United Presbyterian Church. Nevertheless, in preparing it I have also been guided by policy statements of other religious organizations: Catholic, Jewish, and Protestant. In that connection I attach a copy of a document entitled "The Health Care Crisis in the U.S.A., Analysis and Recommendations for Public Policy." You will note that this is an August, 1980 publication of National Impact, an interreligious network of persons concerned about public issues. I ask that this document be made a part of the record. Also attached are the following policy statements of the United Presbyterian Church in the United States of America. I ask that these also be made a part of the record:

1. Toward a National Public Policy for the Organization and Delivery of Health Services [1] (a statement of the 183rd General Assembly [1971] of the United Presbyterian Church.)
2. Health Ministries and the Church [2] (a policy statement adopted by the Program Agency of the United Presbyterian Church in the United States of America and received by the 190th General Assembly of the Church.)

Hence this testimony is not only based on specific policies adopted by the General Assembly of the United Presbyterian Church, but reflects the policies of many other religious organizations of the three major faiths. All of these organizations are concerned for the wholeness of persons as children of God and, therefore, about their physical and mental health. This testimony is therefore believed to be a response to God's command that His followers care for and act on behalf of all His children.

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[1] Minutes of the General Assembly of the United Presbyterian Church in the United States of America, Part I, Volume V, 1971, P. 559 and P. 585.

[2] Minutes of the General Assembly of the United Presbyterian Church in the United States of America, Part I, Volume XII, 1978, P. 70 and P. 307.

In order to comment on the proposals now before Congress to stimulate competition in the financing and delivery of health care it is first essential that we present the basic principles which govern our evaluation and analysis of any proposals in the health care field.

When you as members of the Subcommittee on Health of the Committee on Ways and Means of the House of Representatives prepare legislation on national health care, we believe that the essential and basic principle which should underlie all of your decisions should be:

All persons within the U.S.A. are entitled to adequate health care and the federal government, as the only agency which can act for all the people, should guarantee that entitlement.

That statement is illuminated by the Judeo-Christian ethic, as well as by the history of our nation and our constant striving to adhere to the democratic principles inherent and explicit in the Constitution.

While this testimony deals exclusively with national policy on personal health care services, one cannot ignore the crucial importance of human problems affecting health such as pollution, hunger, poverty, inadequate education, war and of ethical issues arising out of the new biomedical technology. These related issues are high on our agenda. I am sure that they are high on yours also. Important as these concerns are, however, there is a compelling urgency about issues related to personal health care services. These concerns relate to resources and facilities for the delivery of health care, their availability, their quality, their accountability, their cost and, perhaps most important, concerns about justice and equity which pervade the entire health care system. There is wide-spread agreement that there is an urgent need for radical changes in the nation's policy in dealing with personal health care services, but there is obviously wide disagreement as to what changes are needed.

This is especially true with respect to the most frequently mentioned part of the persistent crisis—rapidly rising health care costs and the growing struggle of thousands to pay for them. In that connection, we underscore the utter futility of dealing with the problem of rising costs in isolation. The problem of uncontained health care costs can be successfully dealt with only in conjunction with other components of the health care crisis:

1. Inadequate, mal-distributed resources for delivering health care services.
2. Poorly organized and grossly inefficient systems for delivery of health care services which result in unequal access to health care.
3. Inadequate controls lacking appropriate accountability to government and consumers to assure quality of health care.

In evaluating the current group of bills dealing with the competition based national health insurance, we, therefore, look for features which will enhance a coordinated comprehensive approach. An example of an isolated approach is so-called catastrophic national health insurance. It addresses only one aspect—financing. We insist that the problem of rising health care costs must be addressed in coordination with other aspects of the problem which we have just enumerated.

So we offer our appraisal of the competition based national health insurance and in doing so, measure it against the basic principle which we have already stated:

Do these proposals guarantee adequate health care to all persons within the United States and do they hold the federal government of the U.S.A. accountable for that guarantee?

We realize that in posing that question we imply an almost totally negative evalution of the proposals under consideration.

For example, they provide no commitment to the concept of universal coverage. Indeed, they seem to assure that fewer people will have health care coverage under these proposals than now have it and those who will continue to have coverage are likely to pay more for fewer benefits. Universal coverage is a *sine qua non* for effective national health policy. The competition based national health insurance bills, far from assuring universal coverage move in the opposite direction. Because of their adherence to what we believe to be the misleading principle of fostering competition and reducing costs of the federal government for health care, we predict that if these bills are passed fewer people will have insurance protection than have it today. Furthermore, those that do continue to have some health insurance protection will have less adequate protection and at higher cost to themselves. We cannot commend proposed legislation which we believe will remove people from presently inadequate health insurance coverage and move in the direction of giving them even less coverage at higher costs, even though that may result in savings to the federal budget.

Another general principle which we use in evaluating national health policy proposals is a commitment to comprehensive benefits. Comprehensive benefit suggests that there must be an emphasis on primary and preventive care; that there will be special provisions to encourage continuity of care with easy and unimpeded transfer of patients from one level of care to another; that there will be provision for a wide variety of health care services including such specific things as dental care, very broad inpatient and outpatient care for mental illness, podiatry services, hospice care; that there will be provision for specialized health care services at places of work fully coordinated with family health care services outside of those work places and also an extension of responsibility for long term care of the chronically ill, both in and out of institutions.

Taking that as a broad description of what we mean by comprehensive national health care, it is clear that the competition based bills move in the opposite direction. In the name of fostering competition there is substituted indeed a caveat emptor philosophy—let the buyer beware. The consumer of health care services would have to evaluate the various proposals put forward in the marketplace not only to compare relative costs but predict the extent to which they would offer protection of his or her own health care needs of the future, which, of course, are highly unpredictable. This would be gambling for health care—not guaranteeing it. So the competition based proposals offer neither universal service, nor comprehensive service.

Another important principle which we believe should underscore the evaluation of major changes in national health policy must be whether or not the proposed new policies will begin to contain rapidly rising health care costs. It is clear that the competition based proposals are designed to reduce the financial burden placed upon the federal government. In order to accomplish that goal, however, costs would be shifted to patients, consumers, workers. This would be accomplished by increased deductibles and co-insurance, and in many cases, by adding these costs to existing plans which do not presently have these undesirable features.

We believe that the most effective way to lower costs of health care is to deal realistically and aggressively with the fundamental issues of increased preventive and primary care and to limit inappropriate and unnecessary hospital care. Competition based proposals do nothing to approach these problems and we believe they will continue to encourage the escalation of health care costs.

Another principle, and one in which our Presbyterian policy is explicit, is the necessity for assuring accountability to and participation of consumers in planning and delivering health care services. We find nothing in the competition based proposals which will do anything to add either accountability or participation for public and consumer interests. It is all left to the marketplace under what we believe to be the mistaken notion that free private enterprise will take care of the interests of all. No doubt leaving the rationing of health care to the marketplace will place controls of a kind on the delivery of health care. Those controls, however, will be clearly to the disadvantage of those needing health care most and those least able to afford it.

As we reject the concept of competition based national health insurance, the Committee may well ask, what we suggest as an alternative. In response to that question, we realize how politically naive it would be to suggest consideration by the 97th Congress of a national health service bill or comprehensive bills such as the Health Care For All Americans Act or the Health Security Bill. Those approaches come close to adhering to the principles we espouse. Even those measures do not fully approximate what we would consider an ideal bill, and the policies of the General Assembly of the United Presbyterian Church do not specifically endorse any measure. The competition based bills are so far at variance from those policies as to offer no reasonable basis for detailed suggestions for improvement.

Our proposal at this time, therefore, is that the Subcommittee reject the concept of competition based national health insurance. In making that recommendation we realize that many other organizations also criticized that approach and that some have proposed in considerable detail ways in which the bills might be changed to protect the interests of particular professional or provider groups. In this connection, we find it interesting that the Reagan Administration has not advanced its own proposal in this field. Why? We cannot avoid the inference that the Administration has begun to have long second thoughts on the advisability of pressing forward with its original enthusiasm for these measures.

This being the case, we suggest that it is appropriate for the Subcommittee to delay in reporting these measures and to wait until more evidence is in supporting the objectives they claim. We seriously doubt that such evidence will be forthcoming.

Neither do we suggest that you press forward now with the comprehensive universal national health insurance legislation even though that is the goal which we will continue to advocate. We do believe, however, that even in the present political environment that modest significant steps can be taken in that direction. The most likely area in which this can be achieved is through significant changes in the Medicare and Medicaid laws. We urge you to give serious consideration to any measure which will make Medicare and Medicaid more comprehensive and more universal and which will reduce the cost to patients. For example, we believe it would be a forward step to finance medical care out of general funds rather than from payroll taxes. This would have the immediate effect of helping to ease the Social Security financing crisis and would finance Medicare on a progressive, rather than on a regressive basis. Another change would be to offer free choice to Medicare beneficiaries to get medical care from qualified Health Maintenance Organization plans. We also would encourage legislation which would mandate the Department of Health and Human Services to undertake experiments and demonstrations in prospective reimbursement for Medicare services and through annual per capita payments to physicians and other providers.

In more general terms, we believe that small significant advances can and should be made through improvements to Medicare and Medicaid, until the time when Congress is again ready to consider broad, comprehensive reform in the nation's policy for delivery of personal health care services.

We will be pleased to work with you in developing legislation along these lines.

STATEMENT OF ROBERT Z. ALPERN, SOCIAL RESPONSIBILITY SECTION, UNITARIAN UNIVERSALIST ASSOCIATION OF CHURCHES AND FELLOWSHIPS IN NORTH AMERICA

We appreciate this opportunity to supplement the statement of the United Presbyterian Church, with which we are in general accord, with a brief statement of our own concerns with regard to pending bills to stimulate competition in the financing and delivery of health care.

We are not opposed in principle to the concept of encouraging greater competition in the financing and delivery of health care services. We would caution, however, against gambling too heavily on the magic of free market forces in the realm of health economics. We would also advise a policy of careful experimentation as a prelude to any legislation changes respecting existing federal responsibilities for the funding of health care programs. This cautious approach is particularly appropriate, in our opinion, to the proposed authorization of a "voucher" system to permit the voluntary or compulsory transfer of Medicare or Medicare beneficiaries to some new provider or underwriter of health care services.

These recommendations are derived from three underlying considerations: First, there is very little solid program experience to date to support the expectation of major savings from intensive competition among health care plans. This may well be a promising area for development, but savings should be clearly demonstrated on a pilot basis before major changes are undertaken in existing program structures and funding arrangements.

Second, there is a prevalent attitude in many quarters these days that seeks to measure all proposed social program changes by how much these changes may accomplish in getting costly programs "off the backs of the taxpayers." In Washington the Federal taxpayer's back is the principal concern, but in many state houses and city halls there is a counter-balancing enthusiasm for lightening the load of the state or local taxpayer. This is an understandable concern that deserves serious consideration. Unfortunately, there usually seems to be more attention given to the present bearers of burdens than to the back pains of the prospective bearers of shifted burdens. In such a climate there is a highly sympathetic reception to suggestions that the problem of burdens can somehow be resolved by the magical properties of "free market" operations. Somehow, it is assumed, these benign economic forces will so diminish the costs of care that one need not worry over who is to be stuck with the burdens transferred from the present taxpayers' backs. This is wishful thinking, indeed. These cost burdens are not going to vanish. They are going to end up on somebody else's back—and quite likely, unless we are very careful, on the backs of the old and the poor.

Third, and finally, let us not deceive ourselves that anybody has a secret weapon that will actually halt the spiralling of health care cost. With diligence, and with due attention to innovative approaches, we may slow the rate of cost increases, but despite our best efforts new medical technologies and new research discoveries will continue to make the cost of providing modern medical care even more costly tomorrow than it is today. With this in mind, no major shifts in health cost burdens should be made on the pleasant premise that there is somebody else who can assume the burdens we would like to unload. This is particularly true of health care for the poor and the elderly. They have the greatest needs and the most limited resources, and there is no way in the world that their needs can be met without continued cost sharing by the American people as a whole. New sharing arrangements should be given careful consideration, but there is no future in gambling on wishful economic premises. What we need is to continue what we have until we have developed and demonstrated new and better arrangements.

STATEMENT OF ALAN LEVENTHAL, P.T., NATIONAL LEGISLATIVE CHAIRMAN, AND JOHN MACKO, ESQ., LEGISLATIVE COUNSEL, UNITED SOCIETIES OF PHYSIOTHERAPISTS, INC.

Mr. Chairman and distinguished members of the Subcommittee, we are very pleased that Congressman Jacobs has called hearings on proposals to stimulate competition in the financing and delivery of health care. We are grateful for the opportunity to present this written testimony and we hope to persuade you to enact changes in the medicare law which will increase competition among the providers of physical therapy services. We firmly believe that if competition is increased, the total cost to the medicare system will be reduced significantly.

As you are aware Public Law 96-499 (the Omnibus Budget Reconciliation Act of 1980) enacted significant changes in the medicare law with respect to physical therapy. The medicare system, as amended by Public Law 96-499, provides coverage of physical therapy services as follows:

1. All physical therapy services rendered while a patient is in a hospital by a therapist in the employ of the hospital are covered.
2. All outpatient physical therapy services are covered if they are provided as part of the treatment program given by a physician, a hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency or public health agency participating in the treatment program.
3. Only $500 per year of physical therapy services are covered if the services are rendered by a private physical therapist. (Prior to the passage of Public Law 96-499, the limit was $100).

As we will show, Mr. Chairman, the current law discourages competition and encourages the elderly patient needing physical therapy to use the highest cost provider of the service because it is covered under medicare while lower cost providers are not covered to the same extent. Medicare coverage differs not based upon a difference in the services which are provided, but simply because of a difference in the setting in which the services are provided. Given the same physical ailment and the same kind of treatment, and often the same therapist, the patient's right to reimbursement differs drastically depending upon where the treatments are provided.

While these distinctions are not arbitrary, neither were they designed to optimize the availability of quality care, nor to minimize the cost to the taxpayer. These discriminatory provisions of the current medicare law accomplish neither of these admirable goals.

Current law, in essence, limits patients needing physical therapy at home to obtaining those services only through the auspices, and with the added overhead costs, of certified home health agencies. This is the result of providing an unlimited number of home health visits, while restricting home visits by a private physical therapist to $500 per year. Similarly, the ambulatory patient needing physical therapy is encouraged to use a hospital outpatient clinic because of the unlimited services provided, while coverage of the services of the private practitioner is limited to $500 per year.

The settings for care which are encouraged by the medicare reimbursement system are almost always more costly for the taxpayer. Fees paid to physical therapists working "under arrangement" with approved providers are regulated by HHS and are generally in line with fees charged by private practitioners in the same locality. However, the government pays more for services rendered by "providers" who always add administrative overhead costs to the base rate charged for physical therapy.

For instance, a survey in Brooklyn, New York revealed the following: at Long Island College Hospital, the fee paid to the physical therapist was $20, the fee paid to the agency employing the therapist was $55. At Brooklyn Hospital, the fee paid to the physical therapist was $15, the fee paid to the agency was $25, and so on down the line. The cost to the government for these services is two to three times higher than if medicare had paid the physical therapist directly or reimbursed the patient as they do in the case of other licensed health professionals, such as physicians, podiatrists, optometrists etc. The difference between the amount paid to the institution and the amount received by the physical therapist is due to the administrative costs of the provider system—a cost either non-existent in the private practice setting or absorbed by the private physical therapist.

Further, in a GAO Report issued May 15, 1979, entitled "Home Health Care Services—Tighter Fiscal Controls Needed", the costs of physical therapy and other services delivered by eleven home health agencies in Louisiana and Florida were discussed.

GAO found that per visit charges for physical therapy care delivered by such agencies in high-cost metropolitan areas ranged from a low of $9.18 to a high of $63.20. GAO did not have data which would show the average of the charges covered by the Study. The GAO noted that the major reason for the variances was the excessive administrative and clerical costs in some agencies. It also noted that some agencies were over staffed.

Since medicare essentially allows for the reimbursement of all "reasonable" costs related to patient care, these administrative costs are passed on to the taxpayer. Unfortunately, the GAO data was not national in scope and since the GAO report was based on 1976 data, costs are undoubtedly much higher today. However, it is the only detailed government data on the cost of physical therapy available. (A summary of the GAO Report is attached as Appendix "A").

On June 27, 1979 we had the privilege and opportunity to testify before this Subcommittee. At that time we cited the lack of available cost data. The Committee on Ways and Means in its Report on the Medicare Amendments of 1979 wisely requested the Secretary of Health and Human Services: "To collect and submit data on the costs of physical therapists in independent practice. The Committee also expects that in submitting such data, the Secretary would include national comparisons of costs for physical therapy services furnished by independent practitioners and the cost of such services when provided in all other settings covered under the medicare program" (Report 96-588, Part I, Page 22, November 5, 1979). Unfortunately, this study, to our knowledge, has not been conducted and may not even have been initiated as of this date.

Because of the lack of cost data, the United Societies has attempted to collect cost data on the average cost of a visit to an institutional provider and to a private practitioner. Because of our limited financial resources we were able to study only one regional area (the six county Rochester, New York region). We conducted two separate studies. The first study conducted in preparation for our testimony at the June 27, 1979 hearings used Blue Cross/Blue Shield data for the Rochester region. We examined all Blue Cross/Blue Shield outpatient physical therapy claims (9,561 claims) for the region for the preceding eighteen month period. The data revealed that the average cost of a visit to an institutional physical therapy facility was $61.64. In contrast, the average visit to a private physical therapist cost approximately $20. Recently, more extensive data gathering has been conducted, which further demonstrates the savings potential possible through expanded use of private physical therapists. In the Rochester, New York area cost data has been gathered for 14,360 physical therapy visits for the period from January 1, 1978 to June 1, 1980. This data represents every physical therapy treatment provided by an institutional provider and paid for by Blue Cross/Blue Shield. This data base is one of the most comprehensive available anywhere on the subject. From that data, a sample was selected to provide a confidence level of 95 percent and an expected error rate of less than ±3 percent (see Table I below).

TABLE I.—PHYSICAL THERAPY DATA BASE

Source: Blue Cross/Blue Shield Rochester, N.Y.

Sample Area: Six County Upstate New York Region

Data: 14,360 individual claims paid by Blue Cross for institutional outpatient physical therapy treatments

Period covered: January 1, 1978 through June 1, 1980 (30 months)

Sample size: 361 data points selected at random

Confidence level: 95 percent

Expected error rate: ± 3 percent

Mean (average) cost per treatment: $62.81

Range: Low $4 High $599

Memo: The average cost of a treatment provided by a private practitioner in the same geographic area for the same time period was $20 per treatment.

The data shows that the average cost of a visit to an institutional provider for this period was $62.81. Again, in contrast, the average cost of a private physical therapy treatment was approximately $20. This data base confirms the fact that an institutional physical therapy visit is, on the average, three times as expensive as a visit to a private therapist.

However, as stated earlier, current medicare law often forces the elderly patient to choose the higher cost institutional provider because most, if not all, of the treatments will be covered by medicare if rendered by the intitutional provider. Current law, therefore, penalizes both the patient and the medicare system. The medicare system is burdened by much higher costs. The patient is restricted in his choice of a physical therapist. In essence, the patient cannot freely choose his physical therapist, which may result in reduced patient satisfaction and, perhaps, reduced quality of care.

The recently enacted provisions of Public Law 96-499 will allow a patient to be reimbursed for the first $500 of private physical therapy care and will permit a patient, in many instances, to be treated by a therapist of his choice. This should result in the patient choosing to switch from a higher cost institutional provider to a lower cost private practitioner at a considerable savings to the medicare system. In addition, the $500 provisions will allow more patients to receive needed physical therapy care. Presently there are many situations where an elderly patient cannot obtain needed physical therapy care from and outpatient clinic or through a home health agency. For example, in many rural areas, the local hospital does not have a physical therapy department and the area is not served by a home health agency. In these circumstances the patient is often reluctant to start a program of treatment that will have to be terminated after only five visits because of the current $100 limitation. The $500 limit, which will go into effect January 1, 1982, will provide on the average up to twenty-five visits and will, consequently, enable more patients to receive needed care.

It is important to note that even though the $500 limit will enable more of our elderly to receive needed care, total physical therapy costs to medicare will, in all likelihood, be reduced or remain the same. This is true because for every patient that switches from an institutional provider (at $62.81 per visit) to a private practitioner (at $20 per visit) two additional patients with problems of similar severity can be treated at no additional cost to the medicare system.

In addition, if we assume that as a result of the new $500 limitation, 20 percent of the patient visits for physical therapy treatment (out of an assumed total of one million) shift from institutional providers to private practitioners, we would see a net savings of $42.81 per shifted treatment or $8.6 million.

If 25 percent of treatments shifted from institutional to private practice, savings would top $10 million. This conclusion is based on very limited data. However, all the data available, from private sources, GAO and HHS supports this conclusion.

We believe that the shift may even be greater than 25 percent because physical therapy is a vital and intergal part of the treatment of many elderly patients. There are few areas where the relationship between patient and treating professional is as personal and as time consuming as that between a patient and his physical therapist. A therapist, with whom an arthritic patient or storke victim has developed a relationship of trust, can do far more to help the patient that a stranger.

However, when the elderly patient arrives at a public clinic for treatment, he has no guarantee that he will see the same physical therapist each time. In all likelihood, it will be a stranger. The patient must "re-educate" the physical therapist concerning his particular needs and requirements. In fact, until the new physical therapist learns the needs of his patient, this education process may be physically painful to the patient. This possibility of needless physical pain and psychological trauma faces the elderly patient each time he goes for treatment. As a result, many elderly patients, if given the option, will, Mr. Chairman, surely choose to go to a private physical therapist rather than an impersonal clinic. This shift will occur at a cost savings to the medicare system.

The extent of the shift, of course, cannot be predicted in advance. One mechanism that would surely encourage the voluntary selection of the lower cost provider is to impose comparable limits on all providers of physical therapy services. Currently, there are no limits on higher cost providers, and very severe limits on the lower cost providers. This would appear to be exactly the opposite of what common sense would indicate. If comparable limits were imposed, this would surely lead to increased competition between providers and lower total costs.

For example, comparable limits could be established which limit the annual number of treatments, i.e., visits, to which a patient is entitled—independent of who provides the treatments. If desired, specific limits could be established by type of ailment, e.g., a patient suffering from a hip fracture may be entitled to a total of 60 treatments—independent of who provided the treatments.

Alternatively, the limits could be expressed as a total number of visits per year per patient (an annual limit of 100 visits would cover all but the most serious situations—see Appendix "B").

Currently, institutional providers are not subject to any such limit. The private physical therapist is subject to an annual limit of $500 which covers approximately twenty treatments. Currently, at least in theory, a patient could receive an unlimited number of treatments in a hospital, followed by an unlimited number of treatments from an outpatient clinic or home health agency and still be eligible for up to $500 of treatments from a private therapist. By establishing overall visit limits, competition between providers will be increased and total costs will be reduced because: (1) There will be limits on the total number of visits or treatments; and (2) competition will result in lower treatment costs.

Another approach to reduce cost by utilizing lower cost (but equal quality) providers is to review those laws and regulations which inhibit the use of the lower cost provider.

For example, different hospitals have different requirements. Long term, chronic care hospitals and some specialty hospitals have definite needs for full scale rehabilitation medicine departments staffed by salaried physical therapists. Short term, acute care hospitals have entirely different needs, as do smaller hospitals in rural areas and small communities. The concern in these institutions is to provide intensive medical care to acutely ill patients and patients with recent injuries. Hospitals try to discharge these patients as soon as their medical condition permits. Their care is continued in the office, at home on an outpatient basis, in a long term hospital or in a skilled nursing facility as the individual situation dictates. Physical therapy services in an acute care hospital should be adequate to service the often fluctuating needs of the patients but it is not always necessary or wise for acute care hospitals to have elaborate rehabilitation medicine departments that tend to increase the length of stay in the hospital and reduce the number of beds available to acutely ill patients. Many acute care hospitals recognize this and are drastically cutting down (or eliminating) their expensive rehabilitation medicine departments to more realistic levels.

One factor that discourages hospitals from utilizing private physical therapists in spite of the fact that in many cases the system would be ideal for that hospital, is that the current law limits the reimbursement of physical therapy services performed by private physical therapists to services provided in the physical therapist's office or in the patient's home—but not in a hospital. Different hospitals have different requirements and should be free to meet their needs in the manner best suited for them. Hospitals should be encouraged to utilize less costly, higher quality systems rather than discuraged by a discriminatory medicare law.

CONCLUSIONS

In summary, we urge you to adopt measures which will encourage our elderly to voluntarily choose the lower cost provider of physical therapy because it is in their best financial and health interests.

We have suggested two possible approaches: (1) Impose comparable visit limits on all providers of physical therapy; and (2) remove restrictions on the utilization of the lower cost providers.

These measures will increase competition between providers, improve the quality of care and yet cost less.

Under the approach we recommend, patients would have the option of receiving care in the most convenient setting by a physical therapist of their choice—and the costs would be far lower. This would in no way eliminate State requirements that physical therapy treatment be rendered upon the referral of a duly licensed physician. Private physical therapy practitioners treating patients in a hospital, for example, would have to meet the same standards and follow the same rules as salaried physical therapists on a hospital staff. There is no basis for a fear that quality of care would be lessened. On the contrary, quality would be greatly enhanced, and costs would be lowered.

We wish to clarify that we are not seeking to limit the services offered by home health agencies, nursing homes, hospitals or other "providers". We seek merely to enable the patients and physicians to utilize the less costly services of the private physical therapist without unrealistic restrictions. The patient thus would not be penalized for exercising his freedom of choice of physical therapist. The needs of the patient could be serviced by the private practitioner and patients, hospitals, nursing homes and other "providers" would be free to select which system of physical therapy services best suits their needs.

Mr. Chairman, the most desirable range of choices for providing physical therapy services has been seriously, but perhaps unintentionally, distorted by the medicare law. By making reimbursement contingent on "who bills the patient", rather than on what therapist and on what settings are best for the patient, the law has resulted in a major and illogical shift to higher cost institutional physical therapy treatment. Those patients who have chosen to see private practitioners have unfairly been forced to pay for their choice. Many have gone without needed therapy.

We feel the American public deserves a better system of physical therapy care than the one now part of the medicare program. The program we recommend would be far superior—and yet less costly. We urge the Congress to give it serious consideration. We stand ready to assist in all possible ways.

[Excerpted from GAO Report]

APPENDIX A

CHAPTER 2.—HOME HEALTH CARE COSTS VARY GREATLY

The cost of providing home health care varies greatly throughout the country. For example, for the eight agencies we reviewed in Florida the average cost claimed for a home health visit in fiscal year 1976 ranged from $16.61 to $33.26. Wide variances in unit costs can be explained by a number of factors, and they frequently are a function of utilization. But we have found that a major reason for the variances is that some agencies incur excessive administrative and clerical costs and may be overstaffed.

Medicare essentially allows reimbursement for all costs claimed by home health agencies so long as the costs are found to be related to patient care, reasonable, and not substantially out of line with comparable agencies. In past years these terms have not been defined, but in March, 1979 HCFA published in the Federal Register proposed reimbursement limits for home health services by type of visit.

A nationwide problem

The amount of Medicare reimbursement for home health care varies widely across the country. Examples of such variances are the costs reimbursed for home health care in high-cost metropolitan areas such as Miami, Boston, New York, Chicago, LasVegas and Los Angeles. The table below summarizes the range of these variances.

RANGE OF MEDICARE REIMBURSEMENT FOR HOME HEALTH CARE IN HIGH-COST METROPOLITAN AREAS BY TYPE OF VISIT AND AGENCY WORKLOAD FOR FISCAL YEAR 1976 [1]

Type of visit	Agency workload (visits made)			
	1 to 4,999	5,000 to 9,999	10,000 to 19,999	20,000 +
Physical therapy:				
High	$57.42	$63.30	$40.26	$52.92
Low	9.18	10.00	9.63	12.29
Skilled nursing:				
High	79.19	55.62	35.00	42.72
Low	4.56	5.79	8.95	14.43
Home health aide:				
High	33.27	30.54	31.25	34.72
Low	3.41	5.44	4.85	6.69

[1] Cost reporting periods ending on or before June 30, 1976.

Management and clerical costs

We noted wide variances in the costs of performing various management and clerical activities. As shown by the following table, the costs had little or no relationship to the number of patients served or visits made:

AVERAGE MANAGEMENT AND CLERICAL COSTS, FISCAL YEAR 1976

Agency [1]	Cost	Patients served	Visits made	Average cost	
				By patients served	By Visits made
Florida:					
Dade County	$310,400	2,009	46,670	$154.50	$6.65
Home Health	299,100	1,000	42,626	299.10	7.02
Hollywood	246,700	697	27,440	353.95	8.99

AVERAGE MANAGEMENT AND CLERICAL COSTS, FISCAL YEAR 1976—Continued

Agency [1]	Cost	Patients served	Visits made	Average cost	
				By patients served	By Visits made
Florida—Con.					
Bay Area	$226,400	2,277	56,020	$99.43	$4.04
Broward County VNA	132,600	2,104	40,844	63.02	3.25
Pinellas County	118,200	892	23,503	132.96	5.05
Medi-Health	107,600	710	20,926	151.55	5.14
Hillsborough VND	47,600	1,442	22,251	33.01	2.14
Louisiana:					
HHS/Louisiana	291,400	905	43,212	321.99	6.74
Capital	212,600	704	33,109	301.99	6.42
Golden Age	129,000	1,006	46,699	128.23	2.76

[1] See Appendix I for the complete agency name.

During fiscal year 1976 Dale County, a nonprofit Medicare only provider, had 16 full-time equivalent administrative and clerical employees that received over $208,000 in wages and benefits. During this same period, the agency also purchased substantial administrative services from other organizations. Purchased services included $60,948 for management, accounting, and data processing services, $39,868 for typing services, and $1,620 for board meeting expenses—bringing total management and clerical costs to about $310,400, the highest of all the agencies reviewed. By comparision, the Broward County VNA—which is about 20 miles away—served about the same number of patients and made about the same number of visits, but it incurred approximately $132,600 in similar administrative costs—a difference of $177,800 from Dale County.

APPENDIX B

COMMON AILMENTS OF THE ELDERLY

Ailments of the elderly often require physical therapy treatment. Physical therapy encompasses a wide variety of treatment techniques or "modalities" as they are called within the profession. One or a combination of modalities may be used depending on the particular condition being treated. Patients having the same ailment may require different modalities depending on the individualized problems encountered. The modalities commonly utilized include, among others, various types of heat therapy, hydrotherapy, electrotherapy, as well as ultra sound, therapeutic exercise, massage, traction, gait training, and testing and evaluation procedures. The following paragraphs discuss some of the most common ailments of the elderly which require physical therapy treatments.

Hip fractures

1. Intertrochanteric Fracture of Femur—A bone fracture near the upper extermity of the femur.
2. Subcaptal Fracture of Femur—A bone fracture just below the head of the femur.
3. Joint Replacement—The implanting of an artificial joint to replace a severly damaged joint.

For these three ailments physical therapy is required to relieve muscle strain, restore range of movement, and develop proper gait and weight bearing.

Stroke. A stroke often affects a person's ability to exercise conscious control over muscles, and, therefore, affects the ability to consciously control the movement of an arm, leg, etc. Balance, and therefore the ability to walk, is often affected. Therapy is needed to restore these functions.

Cervical radiculitis (pinched nerve).—Inflammation of a nerve route caused by compression of the nerve canal resulting in neck pain, stiffness, weakness, and numbness in the affected extremity.

Low back pain.—Therapy is needed to lessen persistant pain, spasm, and disability. One type of low back pain is sciatic neuritis.

Adhesive capsulitis (frozen shoulder).—Swelling of the membrane around a joint or connective tissue causing painful and restricted movement. Therapy is needed to restore free movement and reduce painful inflammation.

Arthristis.—Therapy is required to reduce stiffness and pain, improve function, and in some cases to help the patient adjust to restricted movement.

Range of physical therapy treatments required

Ailment	Number
Hip fractures:	
(1) Intertrochanteric fracture of femur	40–80
(2) Subcaptal fracture of femur	40–60
(3) Joint replacement	30–40
Stroke	5–200+
Cervical radiculitis	10–40
Adhesive Capaulitis	10–40
Sciatic Neuritis	5–25
Arthritis	10–40

UNITED STEELWORKERS OF AMERICA,
Pittsburgh, Pa., October 9, 1981.

Mr. JOHN SALMON,
Chief Counsel, Ways and Means Committee,
House of Representatives, Washington, D.C.

DEAR MR. SALMON: On behalf of the United Steelworkers of America, I wish to express our Union's views of the three legislative proposals which would purport to stimulate competition in the health care sector by mandating employee choice among health care plans and by taxing certain employer contribution for such plans.

The USWA represents over one million workers throughout American industry. Approximately one half of our members are concentrated in the primary metals sectors, such as basic steel, aluminum, and nonferrous. Virtually all of our collective bargaining agreements in those industries establishes uniform wage and economic standards for covered workers at plant locations across the country. This means that, in the case of health care plans, workers enjoy a uniform level of comprehensive benefits coverage, regardless of demographic fluctuations from plant to plant, and regardless of the prevailing health care cost structure within each community.

It should be further noted that the Steelworkers Union was first able to establish industry-wide pension and insurance coverage in the Steel Industry only after a lengthy strike in 1949 and after the Supreme Court affirmed labor's right to bargain over such subjects.

Our analysis of the three "pro-competition" bills indicates that legislation of this type will not only fail to achieve the stated objectives of its sponsors, but at the same time it will substantially damage the ability of employers and unions to provide adequate health care coverage for workers through the collective bargaining process. Furthermore, the administrative requirements contained in each proposal will place a severe strain on the ability of labor negotiators to continue to initiate and implement health care cost containment strategies which suit the needs of each particular employment group.

Our Union, as a member of both the AFL-CIO and the Committee for National Health Insurance (CNHI), has participated in the formulation of each organization's position on the three competition bills. We have carefully reviewed the testimony of Mr. Seidman and Mr. Fraser, and we concur with the philosophical and technical objections which they have set forth. We nevertheless, wish to focus our own comments on two specific issues raised by the proposals.

Taxation of employer contributions

All three bills would impose a tax for employer contributions to covered plans beyond either a flat amount or an actuarially adjusted amount. Enactment of this "tax cap" would unfairly punish Steelworkers who have long struggled to achieve comprehensive protection against unavoidable and potentially disastrous health care costs over which they have no real control. No Steelworker ever sought health care coverage as a potential tax shelter.

The complex tax calculations required under each bill would also thwart the collective bargaining process since the computed plan costs could fluctuate widely among employee groups covered under otherwise uniform economic agreements, and the resultant tax liability for individuals may bear no relationship to the true value of his coverage when viewed as part of an overall economic package.

Unions will be compelled to seek additional wage increases to compensate for the additional tax burden. Individuals will be encouraged to risk sizeable front-end deductibles and co-payments under scaled down "qualified" plans in order to avoid tax liability.

Despite a) the onerous administrative burden derived from using the tax code as an incentive for competition among providers, and b) the inequitable manner in which that tax burden would be imposed, there is absolutely no evidence that provider-induced demand for health care expenditures would be diminished.

Transfer of costs

Several components of the legislative proposals including a) the establishment of a Medicare voucher system, b) the mandating of "low option" coverage and rebates to employees, c) the taxation of employees who require comprehensive coverage, and d) the enrollment of non-employee participants into group plans all serve to create a complex but insidious mechanism for transferring health care costs from the public sector to private purchasers and from low-risk to high-risk participants.

The proposal to offer vouchers to older workers and retirees fails to recognize the fact that a sizeable percentage of them currently are covered under privately financed Medicare "wrap-around" plans. To the extent that Medicare recipients are induced through rebates to purchase low option coverage, the cost of negotiated supplemental programs will greatly escalate, once again with no apparent effect upon provider incentives.

Similarly, the availability of low option coverage to healthy individuals will be sure to drive up the cost of comprehensive coverage for high-risk groups. From a collective bargaining standpoint, these cost shifting mechanisms are unproductive and inequitable and will serve to frustrate bonafide labor-management efforts towards health care cost containment on behalf of all covered workers.

For the reasons set forth above, as well as those expressed by my colleagues within the AFL-CIO and the CNHI, I urge the Sub-committee on Health to oppose enactment of HR 850, S.433 and S.139.

Sincerely yours,

LLOYD MCBRIDE.
President.